Aging and Disability Services

Creating choices for elders and adults with disabilities in Seattle-King County

October 2, 2003

2004-2007
Area Plan on Aging

Sponsors
Seattle Human Services Department
King County Dept. of Community & Human Services
United Way of King County

www.seattle.gov/humanservices/ads/

AGING AND DISABILITY SERVICES (ADS)

Pamela Piering, Director

SPONSORS

Patricia McInturff, Director
Seattle Human Service Department (HSD)
City of Seattle

Jackie MacLean, Director
Department of Community & Human Services
King County

David Okimoto, Vice President
Community Services
United Way of King County

ADVISORY COUNCIL ON AGING AND DISABILITY SERVICES

Martha Becker
Joanne Brekke
Gabriel Cohen
Steve Colwell
Thelma Coney
Cleo Corcoran
Timmie Faghin
John Holecek
Adam John
John Kennedy
Yolanda Sanchez-Lovato
Larry Low
Richard McIver
Will Parry
Helen Spencer
Alexandra Tu
Larry Verhei
Suzanne Wiley
Lisa Yeager

Prepared by:
Rosemary Cunningham, ADS Manager – Planning & Technology Support
Karen M. Winston, ADS Planner

Cover Designed by
Hector Sidoine, ADS Administrative Specialist

Special Acknowledgements:
Ozell Bledsoe, ADS Planner
Margaret Casey, ADS Planner
Selina Chow, ADS Manager – Administrative Services
Susan Kinne, UW Center for Disability Policy & Research
Charles Liyab, HSD Finance Analyst
Doug Ricker, ADS Program Specialist
Lin Song, Epidemiologist, Public Health: Seattle-King County
Linda Wells, ADS Planner
Millie So-Ying Wong, HSD Finance Analyst

Table of Contents

Seattle Human Services Department
Aging and Disability Services
618 Second Avenue, Suite 1020
Seattle, Washington 98104-2232
206/684-0660
TTY: 206/684-0702
www.seattle.gov/humanservices/ads/

Aging & Disability Services Sponsors

September 19, 2003

Dear Community Members and Providers:

The next four years bring great promise as we work with the community to create an elder-friendly Seattle-King County region. We believe the four goal areas outlined in the Aging and Disability Services 2004-2007 Area Plan provide a road map to focus our energy on:

- Addressing Basic Needs
- Improving Health and Well Being
- Promoting Social and Civic Engagement
- Increasing Independence for Frail Older Persons and Adults with Disabilities

A noteworthy direction identified here is our movement to build upon evidence-based models that produce results. With the older population becoming more diverse, we are eager to see services expanded to under-served areas and populations. We believe that tracking community indicators in each of the four goal areas will provide decision makers with valuable information to guide future investments in our region.

Each of us takes pride in being a part of the three-sponsor organizational model of Aging and Disability Services. Together the City of Seattle Human Services Department, United Way of King County, and King County Department of Community and Human Services coordinate our planning and investments to create choices for elders and people with disabilities in the Seattle-King County region.

We are confident that our coordination across service systems will continue to make the Seattle-King County region a great place to live for people of all ages.

Patricia McInturff, Director
Seattle Human Service Department

Jackie MacLean, Director
King County Department of
Community & Human Services

David Okimoto, Vice President
Community Services
United Way of King County

Introduction

We are pleased to present the 2004-2007 Area Plan on Aging for the Seattle-King County region. The Area Plan charts the course that the local Area Agency on Aging, Aging and Disability Services (ADS), will follow over the next four years as we seek to create an elder-friendly community. The major goals in this plan outline steps to:

1. Address basic needs
2. Improve health and well-being
3. Promote civic and social engagement
4. Offer services which increase the independence for frail older adults and people with disabilities

Federal law, the Older American's Act (OAA), requires that every Area Agency on Aging involve a number of community partners in the formulation of a major planning document every four years. Responding to this requirement, we have actively involved the community in crafting the Area Plan objectives we hope to achieve. The Area Plan, done through a nine-month public process, began in January 2003 with the ADS Advisory Council's Annual Retreat. The Advisory Council is a 27-member volunteer advisory body established in concert with the OAA to advise ADS on programs and budgets. The Council's mission is to identify the needs of older people and of adults with disabilities in our community, to advise on services to meet these needs, and to advocate for local, state and national programs that promote quality of life for these populations. Members of the Advisory Council have worked closely with staff throughout the Plan's development giving guidance on major objectives and program development.

> **"I**t is not the years in your life but the life in your years that counts."
> Adlai Stevenson

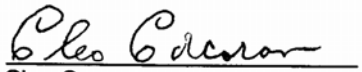
Between January and September 2003 objectives were developed and reviewed by the Advisory Council, service providers, municipal and county councils, ADS staff, and key partners from local universities, health departments, and other organizations. In September 2003 the three ADS Sponsors, City of Seattle Human Services Department, King County Department of Community and Human Services, and United Way of King County, formally adopted the Area Plan on Aging for 2004-2007.

The Area Plan highlights key trends in our aging population:

- Seattle's older population dropped significantly between 1990 and 2000, but was offset by increases in the surrounding suburban areas.
- King County residents who reach the age of 60 can expect to live almost 25 more years thanks to improvements in education, medicine, and nutrition.
- The number of residents 85 years of age and older is climbing fast and will continue to do so for the remainder of this decade.

We hope the Area Plan inspires you to join us in creating an elder-friendly community in the Seattle-King County region.

Pamela Piering
Director
Aging & Disability Services



Cleo Corcoran
Chair
ADS Advisory Council

Mission and Values

Mission

The mission of Aging and Disability Services is ***to develop a community that promotes quality of life, independence and choice for older people and adults with disabilities in King County.***

We will accomplish this by:

- Working with others to create a complete and responsive system of services.
- Focusing attention on meeting the needs of older people and adults with disabilities.
- Planning, developing new programs, educating the public, advocating with legislators, and providing direct services that include the involvement of older adults and others representing the diversity of our community.
- Promoting a comprehensive long-term care system.
- Supporting intergenerational partnering, planning, and policy development.

Values

In fulfilling our mission, we follow these values:

- Older people, adults with disabilities and their families have a right to be treated with respect and dignity and to make decisions affecting their lives.
- Diversity brings richness to our community and within our agency and supports a wealth of ways to capitalize on this strength.
- The support and nurturing provided by family, domestic partners, and friends are important, and we seek to strengthen this capacity.
- Community partnerships are central in bringing together funders, providers, consumers, and community members to develop solutions that address changes in housing, education, health, long term care and advocacy needs.
- The concerns of low-income older people, adults with disabilities, and traditionally underserved groups are recognized, as well as the needs and potential of every member of our community.
- Efforts that encourage independence and enable individuals to remain in their community for as long as possible provide our main focus.
- It is important that older people, adults with disabilities, and those having cultural and language differences within our community have knowledge of and access to the services for which they are eligible.
- Accountability to the public trust means the programs we oversee are consumer guided, responsive and useful.
- Leadership is shared with our regional, state and federal partners and other city institutions as they develop ways to serve older people and adults with disabilities.

Planning and Review Process 2004-07

Through Advisory Council involvement (see Appendix D), public forums, provider questionnaires and other efforts, Aging and Disability Services staff gathered information and comments on the needs of older people and adults with disabilities. In addition, planning documents from King County (*The Human Services Recommendations Report for 2004 – 2006*) and United Way (*The Health & Human Services Community Assessment, 2002 – 2004*) were reviewed as part of the planning process. That information helped shape the development of the Area Plan. During 2003, ADS was involved in the following activities:

- The annual Advisory Council retreat held in January 2003 set the stage for a series of public meetings which launched the Area Plan development process. From February to April, ADS conducted three **Focus on the Future Forums** featuring local experts who conducted "big picture" presentations. Forum topics included:

February 28	*Demographics, Health & Well-Being*
March 18	*Addressing Basic Needs*
April 15	*The Built Environment: Active Living By Design*

- Participation at the public meetings noted above involved approximately **100 individuals** made up of older adults, providers, human service planners, program directors and coordinators, as well as Advisory Council members. As a result of these meetings, themes emerged which helped shape the development of the Area Plan.

- The Healthy Aging Partnership (HAP) coalition reviewed early drafts and gave input.

- Four public hearings were held:

  August 27, 2003
  Riverside Landing
  10201 E. Riverside Drive
  Bothell, WA

  September 2, 2003
  Seattle Human Services Dept.
  618 – 2nd Avenue, 13th Floor
  Seattle, WA

  September 4, 2003
  Tukwila Community Center
  12424 – 42nd So.
  Tukwila, WA

  September 9, 2003
  Mercer Island Community Center
  8236 SE 24th St.
  Mercer Island, WA

Approximately **32 individuals** were present at the Area Plan public hearings. Of those in attendance, approximately 38% were 60 years of age and older and 13% were people with disabilities. Other participants included ADS Sponsors, Advisory Council members, community members, service providers and representatives from the following organizations:

Catholic Community Services
Crisis Clinic
Evergreen Care Network
Mercer Island Youth & Family Services
Northshore Adult Day Care
Northshore Senior Center
Provail Employment & Community Services
SeaMar
Seattle Parks and Recreation Department
Senior Services of Seattle/King County
Sno-Valley Senior Center
United Indian Elder Program
U of W Health Promotion Research Center
Wallingford Senior Center

Public comments received about the Area Plan 2004-07 are summarized in Appendix E.

How ADS Makes Funding Choices

As the Area Agency on Aging for King County, Aging and Disability Services administers federal, state and local funds for services for older people and adults with disabilities. The 2004 budget totals approximately $58 million. Most of this funding ($50 million) is "nondiscretionary" and earmarked for specific services, such as Medicaid Title XIX case management and home care, United States Department of Agriculture meals, and state-funded respite care.

The budget also includes close to $8 million of discretionary funds from the Federal Older Americans Act, the State Senior Citizens Services Act, and local funds from the Seattle Community Development Block Grant and the Seattle General Fund. "Discretionary" funding is more flexible in nature and can be directed to meet priority needs in King County.

> **"L**ife consists not in holding good cards but in playing those you hold well."
>
> Josh Billings

The Advisory Council's Planning and Allocations (P&A) committee recommends strategies to increase or decrease funding to service areas. The committee consists of seven members, each representing one of the ADS sponsoring organizations (City of Seattle, King County, and United Way). Following guidelines and funding priorities established by ADS Sponsors (see Appendix H), as well as the planning and review process described on page 7, the committee developed recommendations for 2004 allocations. Included in the recommendations are priorities for funding should actual revenue exceed the projected level. Funding for the subsequent years in the four year Area Plan period will be determined in the annual allocation process.

The Planning and Allocations Committee based its recommendations on revenue projections, draft Area Plan objectives, client profile reports, service area reviews, and public comment. For a detailed listing of the proposed discretionary allocations for 2004, refer to pages 49 to 54.

Shifting Sands: Demographics in King County

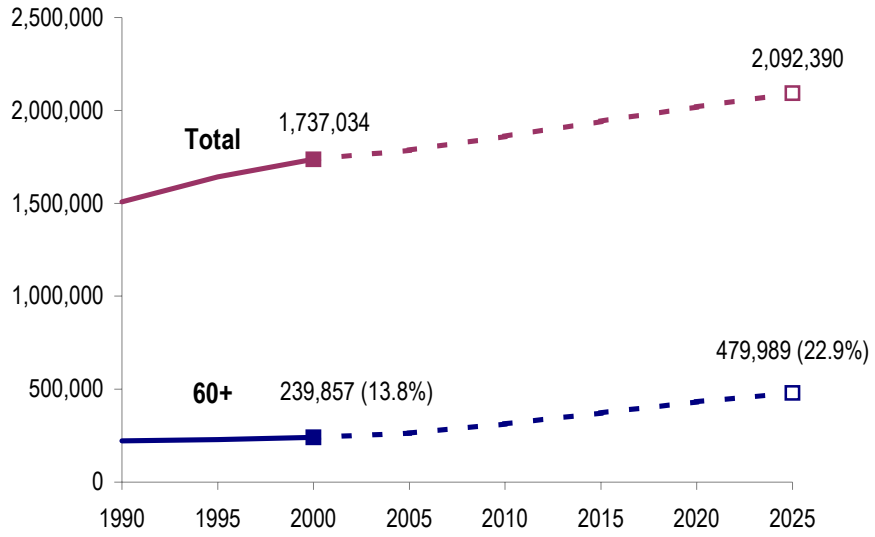
More Older Adults, More Diversity

Thanks to the remarkable improvements in education, medicine, nutrition, and general living standards of the last century, King County residents who reach the age of 60 can now expect to live almost 25 more years. The dramatic increase in life expectancy, from 47 years in 1900 to 79 years in 2000, is one of the main factors contributing to the increase in the number of older adults. As life expectancy rises, the number of "older old" and "oldest old" adults increases. For this reason, programs and policies directed to the 60 and over population must take into account the needs of up to three generations of older adults.

In addition to generational differences, the older population is extremely diverse in health, social, and economic status. While most older adults between the ages of 65 and 74 are active, healthy, and independent, those who are 85 years and older are more likely to face problems of ill health and loss of independence. Although the number of older adults is on the rise, disability rates are declining, an encouraging trend that policy makers are watching. On the other hand, health and income disparities across ethnic groups which are already pronounced will have a greater impact on quality of life in the future as a more diverse cohort of King County residents ages into the 60+ group.

King County Is Growing Older

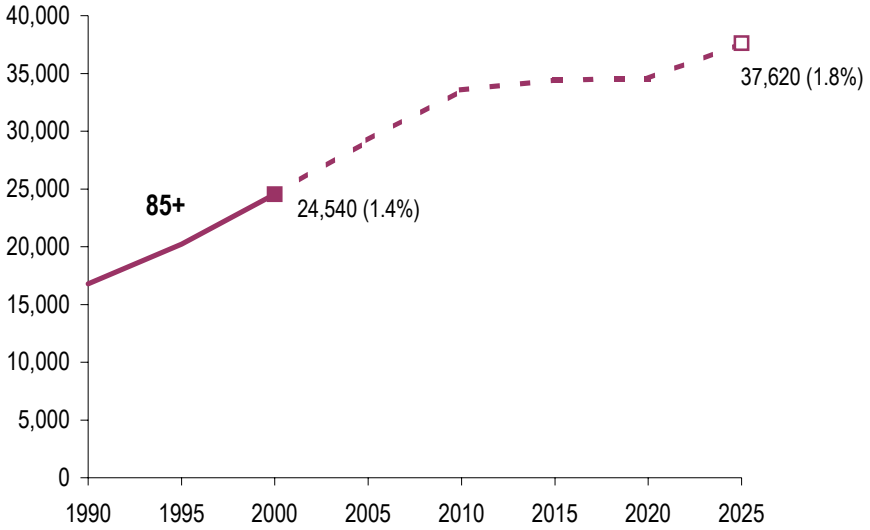
Figure 1. King County Total and 60+ Populations, 1990-2025



Sources: Census 2000; WA Office of Financial Management

Between 2000 and 2010, King County's 60 and older population is expected to grow in absolute terms (from 239,857 to 313,456) and as a share of the total population (from 13.8% to 16.8%). This follows the relatively stable decade of 1990-2000, when this population increased modestly in number, but decreased in share. The increases expected this decade are a prelude to more dramatic increases in the decades to come, as the baby boomers begin to retire. It is estimated that by 2025, the 60+ cohort will represent almost a quarter of the County population. While the number of 60+ residents is expected to see the most dramatic increases after 2010, the number of 85+ residents is already climbing fast and will continue to do so for the remainder of this decade. It should then level off until around the year 2030, when the boomers reach this age.

Figure 2. King County 85+ Population, 1990-2025

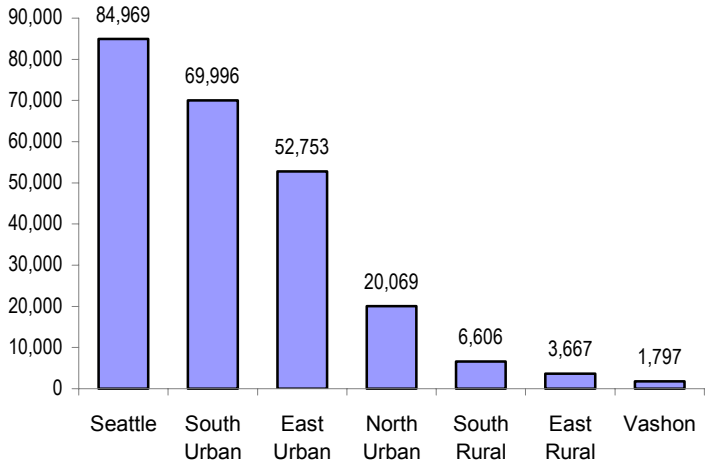


Sources: Census 2000; WA Office of Financial Management

Map 1 in Appendix A shows the total number of 60+ residents by census tract. Map 2 shows the changes in this population from 1990 to 2000. Note that Seattle's older population dropped significantly during this period, but this was more than offset by increases in the surrounding urban areas.

ADS follows King County when dividing the county into seven subregions for planning purposes – Figure 3 shows the breakdown of the 60+ population by subregion. Most older people live in the Seattle, South Urban and East Urban subregions, while Vashon has the smallest 60+ population.

Figure 3. 60+ Population by King County Subregion: Total 239,857



Source: Census 2000

The average King County resident born in 2000 can expect to live 79.2 years. There is wide disparity, however (Table 1 below) – Asians, who have the highest life expectancy, can expect to live over 10 more years than African Americans. At age 65 average life expectancy is 83.8 years – meaning the typical 65-year-old in King County can expect to live another 18.8 years. Compared with 1995 data, life expectancy at 65 rose for every group except African Americans and Native Americans, who saw decreases of 0.4 and 1.5 years, respectively.

Table 1. Life Expectancy by Race and Hispanic/Latino Ethnicity at Birth and Age 65 – King County

	At Birth	At Age 65
Asian & Pacific Islander	84.2	87.6
Hispanic Ethnicity*	83.6	87.0
White	79.3	83.7
African American	73.8	81.4
Native American	73.9	81.3

* overlaps with other categories

Source: 1991-2000 Population Estimates: EPE Unit, Public Health-Seattle & King County

The Older Population Is Becoming More Diverse

Gaps in life expectancy have remained fairly constant across racial groups in recent decades.[1] However, people of color will make up an increasing proportion of the older adult population as a more diverse cohort of Americans reaches retirement age. This trend is expected to continue for the foreseeable future: In 1990, persons of color represented less than 10% of the County's 60+ population, but this increased to 15% in 2000, and is expected to reach 33% by 2050.[2]

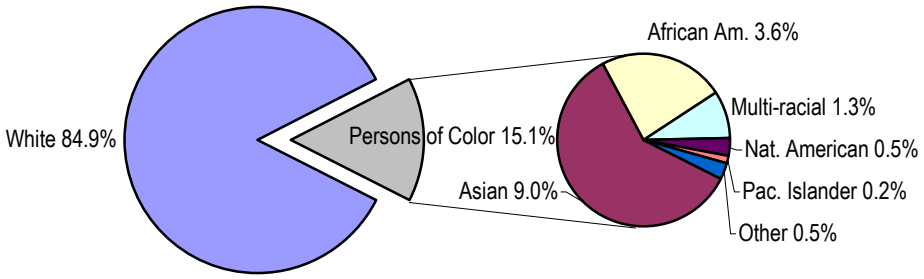
Table 2. Population Age 60+ by Race and Hispanic/Latino Ethnicity in King County

	#	%
White	203,594	84.9%
Asian	21,646	9.0%
African American	8,573	3.6%
Multi-racial	3,174	1.3%
Native American	1,301	0.5%
Other	1,151	0.5%
Pacific Islander	418	0.2%
Total	*239,857*	*100.0%*
Hispanic/Latino*	3,627	1.5%

* overlaps with other categories

Source: Census 2000

***Figure 4*.** King County Population 60+ by Race



Source: Census 2000

As the data on life expectancy (Table 1 above) and disability (Table 6 below) illustrate, increasing numbers is not the only – or most important – story regarding older persons of color. Policymakers need to address persistent inequalities in health outcomes between racial and ethnic groups.

[1] *Demography Is Not Destiny*, 1999. http://www,cityofseattle.net/humanservices/ads/ABOUTUS/AP-Update%2702-%2703.pdf
[2] *Demography Is Not Destiny*, 1999. http://www,cityofseattle.net/humanservices/ads/ABOUTUS/AP-Update%2702-%2703.pdf

Washington state demographic data show that:

- About 27% of the 60+ population lives in King County
- Almost 45% older people of color reside in King County (see Map 3 in Appendix A).
- Washington is the fourth largest refugee resettlement state in the United States.
- Since 1996, 41% of refugee new arrivals resettled in King County.
- The majority of County refugees are from Southeast Asia (65%), followed by the former Soviet Union/Eastern Europe (21%), Africa (10%), and the Middle East (2.4%).[3]

Language can be a major barrier to services for these and other groups. According to the 2000 census, 5.3% of King County 65+ residents speak English either "not well" or "not at all." As Table 3 shows, older Asians, Pacific Islanders and Hispanics/Latinos are most likely to have difficulties with English.

Table 3. Limited English Speaking 65+ by Race and Hispanic/Latino Ethnicity in King County

	Total 65+	Limited English†	% of Total
White	156,196	2,588	1.7%
Asian	15,460	6,288	40.7%
African American	6,163	122	2.0%
Multi-racial	2,147	361	16.8%
Native American	823	2	0.2%
Other	719	225	31.3%
Pacific Islander	264	84	31.8%
Total	*181,772*	*13,533*	*7%*
Hispanic/Latino*	2,350	469	20.0%

* overlaps with other categories

† Limited English = respondents who speak English "not well" or "not at all."

Source: Census 2000

Poverty Rates Have Increased For Older People, Disparities Persist

Despite the County's booming economy in the 90's, poverty rates for older persons rose slightly. In 1990, 11,569 (6.9%) County residents 65+ were living below poverty; by 2000 this had risen to 12,937 (7.1%). With the collapse of the stock market bubble in 2001 and a continuing weak economy, it seems likely this trend has continued.

Map 4 in Appendix A shows the number of 65+ adults below poverty in each County census tract. Pockets of poverty can be found throughout the County. Map 5 shows the change in poverty levels from 1990 to 2000 – Kent and Auburn show particularly worrisome increases.

[3] 2002 Refugee Service Delivery Plan for King County, King County Refugee Planning Committee, April 2002

In King County, older African Americans and persons of two or more races have the highest poverty rates, followed by Asians, those in the "other" census race category, and Hispanics/Latinos.

Table 4. People with Incomes Below Poverty by Race and Hispanic/Latino Ethnicity in King County

	Total 65+	65+ Below Poverty	% of Total
African American	6,163	1,089	17.7%
Asian	15,460	2,462	15.9%
White	156,196	8,808	5.6%
Native American	823	89	10.8%
Other	719	109	15.2%
Multi-racial	2,147	370	17.2%
Pacific Islander	264	10	3.8%
Total	*181,772*	*12,937*	*7.1%*
Hispanic/Latino*	2,350	339	14.4%

* overlaps with other categories

Source: Census 2000

In terms of ADS' planning regions, the poverty rate among the 65+ population is highest in Seattle (9. 9%) and lowest on Vashon Island (2.3%).

Table 5. 65+ with Income Below Poverty by King County Subregion

	Total 65+	65+ Below Poverty	% of Total
East Rural	2,565	120	4.7%
East Urban	38,952	1,835	4.7%
North Urban	15,319	752	4.9%
Seattle	67,804	6,709	9.9%
South Rural	4,679	359	7.7%
South Urban	51,126	3,132	6.1%
Vashon	1,327	30	2.3%
Total	*181,772*	*12,937*	*7.1%*

Source: Census 2000

Older People Today Live Healthier Lives

The increasing number of older persons implies a greater need for services targeted to this population. However, this may be mitigated somewhat by the fact that older people are living healthier lives. Several recent studies have found decreasing rates of chronic disability among the older population[4]. A 1998 Rand study also found large declines in functional limitations (seeing, lifting and carrying, climbing, and walking) especially for those who were 80 years and older. In addition there were significant improvements in functioning for the 65 to 79 year old group.[5]

It is not clear which trend – rising numbers of older adults or lower rates of disability – will "swamp" the other in terms of the future need for services. This is a critical question for planners and service providers. Adding to the uncertainty, it is also not clear how long the trend toward lower disability rates will continue.

Data is lacking on whether disability decline is benefiting all racial/ethnic groups equally. It is clear, however, that significant disparities remain. In King County, older African Americans and older persons from two or more races have significantly higher rates of disability than other racial groups.

Table 6. Older People with Disabilities by Race and Hispanic/Latino Ethnicity in King County

	Total 65+	65+ With Disability	% With Disability
African American	6,163	3,183	51.6%
Asian	15,460	6,195	40.1%
White	156,196	58,227	37.3%
Native American	823	358	43.5%
Other	719	303	42.1%
Multi-racial	2,147	1,278	59.5%
Pacific Islander	264	103	39.0%
Total	*181,772*	*69,647*	*38.3%*
Hispanic/Latino*	2,350	1,011	43.0%

* overlaps with other categories

Source: Census 2000

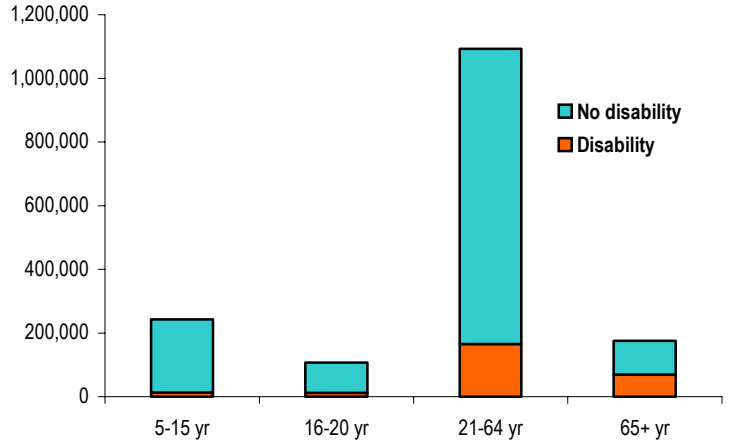
[4] Freedman, V. A., Martin, L.G., & Schoeni, R.F.. Recent trends in disability and functioning among older adults in the United States: a systemic review, *Journal of the American Medical Association*, Vol. 288, No. 24, December 2002, pp. 3137-3146.

[5] Freedman, Vicki A. & Martin, Linda, G. Understanding trends in functional limitations among older Americans*, American Journal of Public Health*, Vol. 8, No. 10, October 1998, pp. 1457-1462.

Most People With Disabilities Are Not Older Adults

Nearly 20 percent of Americans have a disability, and 15% have severe disabilities. [6] Although rates of disability in the County are higher among adults 65 and older, a higher *number* of adults with disabilities are in the 21-64 age range.

Figure 5. Number of Disabled/Non-Disabled County Residents by Age Group



Source: Census 2000

People with disabilities and chronic illnesses who require long term care consist of diverse populations. Although younger people with disabilities have many service needs in common with older adults, subgroups may have specific needs that differ from those of older adults.

Nationally, the percentage of working-age persons with disabilities declined during the 90's, from 14.3% in 1990 to 10.3% in the year 2000. The percentage of these people unable to work due to their disability fell from 6% to 5.1% during this period. These declines followed three decades of increasing disability rates.

In the 90's, rates of disability due to back problems, arthritis and rheumatism, heart problems, and hypertension all declined somewhat. However, an increase was seen in disabilities attributed to mental health conditions.

[6] *Americans with Disabilities: Household Economic Studies* using data from the 1997 Survey of Income and Program Participation.

Services Provided Through the AAA

Service Area Descriptions

Aging and Disability Services funds the following eighteen services to older adults and adults with disabilities who live in King County. The number of clients served and the funds allocated in each of the service areas are listed on pages 55 through 66. Most of the services are provided by a network of community-based organizations located throughout King County who subcontract with ADS to provide services. In addition, ADS provides direct case management services to approximately 4,000 clients.

Adult Day Services

Adult Day Services are provided to adults with disabilities in order to prevent or delay the need for institutional care. Participants attend centers during the day on a regular basis and receive care designed to meet their physical, mental, and emotional needs.

Services at ***adult day health centers*** include rehabilitative nursing, health monitoring, occupational therapy, personal care, social activities, activity therapy, and a noon meal.

Services at ***adult day care programs*** are usually less medically oriented, providing health monitoring services as well as socialization activities and a noon meal.

Alzheimer Program

This program is designed to facilitate the development of an infrastructure that will support a holistic model of care for Alzheimer's patients. It involves the collaboration between primary care physicians, dementia care specialists and social care programs.

Caregiver Information and Support

Caregiver information and support focuses planning on both the individual caregiver and the system that supports the caregiver. It includes in-home and out-of-home respite care services for family and other unpaid caregivers that provide the daily services required when caring for adults with functional disabilities. ADS administers funds that support caregivers information and assistance, support groups, caregiver training, respite care services, translating/interpreter services, and specialized transportation. Depending upon the funding source, services range from kinship care for grandparents (age 60+) caring for relatives, to caregivers caring for persons age 18 and over.

Case Management

Case Management provides in-depth assistance to frail, multiple needs persons who have significant health and social needs. The case managers conduct in-home assessments and consult with the client in order to develop and implement a service plan that addresses the individual's needs.

Case managers have regular follow-up contact with clients and service providers to ensure that their situations have stabilized. Short-term counseling is provided if needed. Screening and referral for case management services are provided through the Information & Assistance programs, and the state DSHS Home and Community Services.

Amy Wong Client Fund
Services are individually tailored to meet each client's specific needs so that they are able to stay in their own home. Such services are authorized by case managers and provided through ADS service providers as well as outside vendors.

COPES/Chore Personal Care/Personal Care
COPES, Personal Care and Chore Personal Care support individuals who are unable to care for themselves. Services include assistance with dressing, bathing, eating, toileting, and transferring. Limited household services are also available to maintain individuals in a safe and healthy environment.

Disability Access Services
Services provided include case management, interpretative services and advocacy for persons who are blind, deaf-blind, or hard of hearing. Other services include training to community agencies and advocacy related to facility and program access by persons with disabilities. New components include 1) information and referral services, and 2) FLASH (Fun, Leisure, Access, Savings and Health) card and an enhanced website for adults with disabilities.

Disease Prevention/Health Promotion
The Senior Wellness Project widens the access of older adults who face limitations in their activities of daily living to low-cost, high-quality and comprehensive health promotion programs located in community sites. These research-based programs include an exercise program offering one hour supervised classes, a seven session course led by trained volunteers providing tools for living a healthier lifestyle with chronic conditions, and a health enhancement program which provides personal guidance and support to maintain and/or improve health.

Elder Abuse Prevention
Gatekeepers and other members of the community are trained to recognize signs that may indicate that a vulnerable adult is at risk of abuse, neglect or exploitation and how to report their concerns.

The residential Long Term Care Ombudsman Program is designed to improve the quality of life for residents of nursing homes, congregate care facilities, boarding homes and adult family homes. With the assistance of trained volunteers the Ombudsman investigates and resolves complaints made by or on behalf of residents, and identifies problems that affect a substantial number of residents. Changes in federal, state and local legislation are also recommended by the program.

Employment
Job placement assistance is provided to job seekers over age 55. Part time community service employment opportunities are available for low-income King County residents age 55 or older.

Home Health and Health Maintenance

Home Health and Health Maintenance services are medical services provided to individuals in their own homes on a visiting basis. Such services may include professional nursing services, physical therapy, occupational therapy, speech therapy, and/or home health aide services.

The individuals receiving services must be under the care of a physician, and services provided must be specified in a plan established and periodically reviewed by a physician. Home health services funded by Aging and Disability Services are only for people who are not eligible for Medicare, Medicaid, or third party payor coverage.

Homesharing

The homesharing program helps older adults remain independent and living in their own homes while providing safe, affordable housing choices for people of all ages. The program carefully matches older homeowners with tenants needing low-cost housing while providing companionship and security to both.

Information and Assistance

Primary Information and Assistance (I&A) connects older adults with the services and information they need. Information is provided over the telephone and in-person. Assistance in contacting services is also provided for clients who are unable to do so themselves. I&A staff screen clients to determine their need for more extensive services, which are provided by the case management program.

Special Information and Assistance programs provide services to older persons who are not able to use the primary I&A program due to language, cultural, racial or social barriers. The five Special I&A programs serve Asian/Pacific Islander, African-American and Hispanic elderly persons, public housing residents, and homeless elders. Services are provided by bilingual staff via telephone, office and home visits.

Legal Services

Legal services provides group legal representation, including class action lawsuits, advocacy training and information to service providers, private attorneys and volunteer advocates, and individual client legal services. The purpose of Legal Services is to enable older people to secure rights, benefits and entitlements under federal, state and local laws. It also seeks to effect favorable changes in laws and regulations that affect older people. Additionally, Legal Services strives to maintain public and private resources that benefit low-income elderly people.

Mental Health

ADS funds are targeted to clients who may be resistant to receiving services by offering mental health consultation support to case management staff.

Nurse Consultation

The nursing services program focuses on high risk older people and disabled adults with medically unstable health conditions. Services provided include appropriate referrals and coordination with health care professionals. The frequency and amount of service is based on individual need that is defined by eligibility and client assessment.

Nutrition

The Congregate nutrition program helps meet the dietary need of older people by providing nutrition education, and nutritionally sound lunches served in a group setting. Nine agencies manage 59 nutrition sites located throughout King County. Twenty of the sites serve ethnic meals once a week, or provide ethnic-specific food to African American, Hispanic, Native American or Asian community members. There are also 22 sites provided through Senior Centers.

The home delivered meals program, often known as "Meals on Wheels," provides nutritious meals to older people who are homebound and unable to prepare meals for themselves. Frozen meals are delivered to individuals throughout Seattle and King County. Hot, home delivered meals targeted to African American, Hispanic, Native American and Asian elderly people are available.

Nutrition outreach to increase the participation of Hispanic elders in nutrition programs is another subcontracted nutrition service. In addition, registered dietitian consultation is provided to the ethnic-specific nutrition programs to ensure compliance with dietary requirements.

Outreach Advocacy

The African American Outreach program identifies older people who do not come into contact with traditional referral sources. The purpose is to inform older people about available services and encourage their participation in aging programs.

Outreach Advocacy workers provide some direct services, such as completing forms and applications, and arranging transportation if an older person is unable to do so and has no other available means of assistance.

Respite Care

Respite Care services focus on meeting the needs of caregivers by providing them time away from the responsibilities of ongoing care of a disabled adult. The care that is provided ranges from companionship and supervision to care provided by a registered nurse. Respite care is provided both in-home and in the community.

Senior Centers

Aging and Disability Services administers local funds that support a number of Senior Centers in the City of Seattle. Senior Centers are community resource centers that meet the physical and emotional needs of older adults by offering access to services and resources on site, including immunization, health screening, nutrition, exercise and fitness programs.

Seniors in Service to Seattle

This volunteer program, funded with local dollars, uniquely promotes volunteer and intergenerational relationships by finding opportunities for seniors age 55 or over in City departments, schools and community based programs.

Technology Support

Funding is provided to subcontractors as part of their operating costs for upgrade and maintenance of their information systems, for purposes of client tracking and reporting, for training, and fiscal management.

Transportation

Aging and Disability Services primary focus for transportation in King County is to provide access to nutrition services. ADS works in partnership with Metro/King County to provide transportation to nutrition sites. ADS also funds Volunteer Transportation, which provides rides to medical appointments on a priority basis.

Utility Discount Program

Discounts in electric, water and solid waste bills are available to Seattle low income families, home owners or renters who are age 65 or older, or under 65 and disabled.

B3. Non-AAA Services Available in the Planning & Service Area

This chart should not be considered as an all-inclusive listing of services in King County. Instead, it indicates the types of organizations and services available for older people, adults with disabilities, and their families.

SERVICE	South King County	East King County	North King County	Seattle	Serves all of King County
Case Management Programs	X	X	X	X	X
Developmental Disabilities-focused	X	X	X	X	X
Disability/Issue Groups	X	X	X	X	X
Elder Abuse	X	X	X	X	X
Employment Services	X	X	X	X	X
Food Banks	X	X	X	X	
Homeless Programs	X	X		X	
Hospitals/Medical Centers, Medical & Dental Clinics	X	X	X	X	
Housing (includes King County and Seattle Housing Authorities	X	X	X	X	X
Geriatric Mental Health services, Alcohol/Substance Abuse Programs & Psychologists	X	X	X	X	X
Older Gay, Lesbian, Bi-Sexual, and Transgender Programs				X	
Other Services	X	X	X	X	X
Refugee/Immigrant Services	X	X	X	X	X
Senior Fitness and Social Programs	X	X	X	X	
Disability and Senior Information and Assistance Services	X	X	X	X	X
Services to Ethnic Groups	X	X	X	X	X
Spiritual/Faith-based Organizations (i.e., temples, synagogues, churches)	X	X	X	X	X
Transportation	X	X	X	X	X

Issue Areas and Objectives

Aging and Disability Services is joining with 12 Area Agencies on Aging (AAA) in a coordinated effort to build elder-friendly communities across the state of Washington. Each AAA Area Plan is using the AdvantAge Initiative community-building framework to "create vibrant and elder-friendly communities that are prepared to meet the needs and nurture the aspirations of older adults". [7] The AdvantAge Initiative is based on a comprehensive survey of older adults who live at home. Consumer information from the surveys enables professionals who develop policies and plan programs to hear a range of community voices. The survey is also a tool to engage more older people in the dialogue about aging issues. Finally, by coordinating efforts across the nation, AAAs can build support for action plans and policy decisions.

The AdvantAge Initiative is gathering survey data from across the U.S. to develop baseline community indicators that will guide resource and program planning efforts to create an elder-friendly community that:

- Fosters opportunities for older residents to remain active, contributing members
- Supports the health and well-being of older residents who wish to live independently in their homes for as long as possible, and
- Provides help and support to community-residing older people when needed, particularly to the very old, frail, and homebound.

The four priority issue areas included in the ADS Area Plan 2004-2007 are:

1. Basic needs
2. Health and well-being
3. Social and civic engagement
4. Independence for frail older adults and people with disabilities

> **"D**estiny is not a matter of chance; but a matter of choice. It is not a thing to be waited for; it is a thing to be achieved"
>
> William Jennings Bryant

Each issue area contains:

- Background information
- Broad goal
- Measurable objectives
- Community indicators

In addition the State Unit on Aging requires that ADS highlight issues of importance to Native American and rural elders throughout the plan.

ADS determined the size of the change proposed in each of the objectives by considering the following factors: population growth in King County over the next four years, the feasibility of reaching the target given funding levels, and the AAA current service capacity in King County. During the first year of the plan, ADS will gather baseline data for community indicators from the Communities Count Report [8] and AdvantAge Initiative. In addition, ADS will gather service data annually to measure progress on objectives.

[7] The AdvantAge Initiative, www.vnsny.org/advantage/whatis.html, August 2003.
[8] Communities Count 2002: Social and Health Indicators Across King County. www.communitiescounty.org

Basic Needs

Background

Most Americans will remain in their own homes and communities as they grow older. In an effort to create vibrant and elder-friendly communities in King County, ADS will address the basic needs of older people the following areas:

- Affordable housing designed to accommodate mobility and safety,
- Mobility for shopping, social, and medical visits, and
- Access to information and assistance about services in the community.

The specific needs of Native American elders and rural elders are also highlighted.

People need affordable housing. The demand for affordable and accessible housing with services for older adults and people with disabilities exceeds the existing housing stock in King County. Affordable housing is defined as mortgage or rent and utilities that do not exceed 30 percent of the household's annual income. In 1994 7.5% of senior households in Washington State spent more than 30% of their income on housing.[9] Several factors contribute to a growing gap between the demand for and availability of housing with services over the next four years (2004 – 2007):

Men will live an average of six years and women an average of 11 years after they stop driving.

- Increasing population of older adults and people with disabilities who are living longer,
- Lack of an adequate number of Section 8 vouchers, and
- Growing high costs in the housing market in the Puget Sound.

Mobility links, including transportation, are limited. Transportation mobility links older people with goods and services and social and community activities.[10] In most communities, older people travel primarily by private vehicle. This trend is expected to continue as the number of older drivers is expected to increase 2.5 times during the next 25 years, while the older population (65 years and older) will double.[11] This increase reflects personal preferences for the convenience and flexibility of driving private vehicles. Yet men will live an average of six years and women an average of 11 years after they stop driving.[12] Of great concern to drivers who decide to quit is the affordability, availability, and safety of alternative modes of transportation.

Linking older people with goods, services, and activities in the community will become a greater challenge as people outlive their ability to drive. The topography of King County, its urban and rural sprawl, as well as automobile-dominated planning and development limit the continued mobility and independence of older people and adults with disabilities. Furthermore, only three percent of older people use public transit[13] due to concerns about safety, schedules, and connections to needed destinations.

More people use information and assistance to access appropriate benefits and services. Older adults, friends, relatives, and advocates contact Information and Assistance (I&A) programs to get information about and access to health and long-term care services and benefits. There are three ways people can get information in King County:

---

[9] Washington State Affordable Housing Advisory Board Report, 1994.

[10] Glasgow, n. & Blakely, R. "Transportation transitions and social integration of nonmetropolitan older persons". In Pillemer, K. etal. eds., *Social Integration in the Second Half of Life.* Baltimore: Johns Hopkins University Press, 2000.

[11] Burkhardt, J.C. et.al., *Mobility and Independence. Changes and challenges for older drivers*. Final report, U.S. DHHS and NHTSA, 1998.

[12] Foley, D. et al. "Driving Life Expectancy of Persons Aged 70 Years and Older in the U.S," *American Journal of Public Health,* August 2002, vol 92, no. 8.

[13] Rosenbloom, S. "The Mobility Needs of the Elderly," *Transportation in an Aging Society: Improving Mobility and Safety for Older Persons,* Washington, D.C.: U.S. DOT, 1995.

1) people who speak English can call the county-wide telephone based I&A service; 2) people who are limited English speaking, live in public housing or in downtown Seattle can contact I&A advocates in person; and 3) anyone can download information from a web-based list of more than 8,000 resources.

More people are becoming aware of the I&A resource in the community due to two successful outreach campaigns: 1) the Healthy Aging Partnership 4Elders outreach campaign, and 2) the Benefits CheckUp outreach initiative. From 2000 to 2003 there has been a dramatic increase in the number of people who access the 4Elders web site, www.4elders.org and its accompanying toll free phone line 1-888-4Elders. The number of hits to the web site has increased from 4,000 in the year 2000, to 74,179 hits in 2002, with 114,660 hits projected for 2003. The number of calls to the 1-888-4Elders line has increased from 1,344 in 2000 to 4,640 in 2002, with over 6,000 calls projected for 2003.

A growing number of people are contacting local I&A programs for help with screening for benefit eligibility. Millions of older adults across the U.S. are eligible for health and supplemental income benefits, but are not receiving them. BenefitsCheckUp is an online service, sponsored by The National Council on Aging, containing 1,150 programs that was developed to address this problem. People age 55 and over in King County access BenefitsCheckUp either directly or through their local I&A program. They can find out what federal, state, and local benefits they are eligible for and print out application forms as needed. Since Benefits CheckUp was launched in 2002, 362 King County residents have accessed the website through and I&A program, with 75 people requesting assistance by using the tool. Recognizing the severe impact high cost prescription drugs are having on the ability of older adults to make ends meet, Benefits CheckUp added features for prescription drug discount screening. Increased outreach and training are needed to increase the number of people using the screening and application tool.

Accessing human services will become more streamlined for King County residents when the 2-1-1 phone line is launched locally. 2-1-1 is the national abbreviated dialing code for free access to health and human services information and referral (I&R). 2-1-1 is an easy-to-remember and universally recognizable number that makes a critical connection between individuals and families in need and the appropriate community-based organizations and government agencies."[14] United Way is leading the planning effort in King County to roll out the 2-1-1 Information and Assistance line by December 31, 2003. Older adults will benefit from the behind-the-scenes coordination of resource listings and web sites by local I&A organizations which will result in an efficient, seamless referral source.

Native American elders need better access to services. According to Census data, the number of Native American people over 55 years of age living in King County has increased from 1,745 to 1,972 over the past decade. However, studies show that the American Indian population is undercounted in the Census data.[15] In addition, a large percentage (63%) of Native Americans is moving to urban areas. Over 200 tribes are represented in the King County region. Because they are dispersed among the general urban population, Native American elders have no special governmental agencies responsible for their needs. As a result, urban Indians have been called the 'Invisible Minority' because the dominant culture ignores their health needs and even their existence and they generally do not benefit from public resources available.

[14] www.211.org

[15] Robert, John. "Aging Among American Indians: Income Security, Health, and Social Support Networks," *The Gerontological Society of America, Minority Elders: Five Goals Toward Building a Public Policy Base,* p.66, 1994.

Due to strong historical trends toward genocide, racism, and traumatic boarding school experiences among grandparents and elders they fear and avoid community service delivery systems. This translates into further medical, financial and social vulnerability.[16]

Of the 1,972 Native American people who are over 55 years of age and are living in King County, 375 (19%) received ADS services in 2002 ranging from nutrition to case management. Native American community members in King County cite the following barriers to service:

- Lack of a culturally specific service delivery system,
- Lack of assistance to apply for benefits and services,
- Failure to listen to and respect elders' concerns,
- Failure to identify where Native American elders live in King County, and
- Failure to identify specific needs of Native American elders.

Gay/Lesbian/Bisexual/Transgender elders need better access to services. For social, cultural, and legal reasons, the needs of elder LGBT people differ from heterosexual and/or non-gender variant people. LGBT people who are currently seniors came of age prior to the gay rights movement, during a time when people were subject to persecution, institutionalization, and even incarceration, because of their sexual orientation and gender identity. Due to this type of intense discrimination, this generation tends to be secretive and fearful of disclosing their sexual orientation or gender identity. This lack of visibility creates a situation in which it is nearly impossible to get accurate demographic information on this population.

Knowledge of a client's sexual orientation in a health or social service setting is crucial to the provision of appropriate, sensitive, and individualized care. It is known that individuals who do not feel a sense of rapport with service providers are less likely to follow treatment regimens or return for follow-up services. Providers who lack awareness of their LGBT clients do not address their specific needs, sacrificing care without even knowing it. If health and social service agencies are not sensitive to the needs of LGBT seniors, there is a high risk that clients will be alienated from seeking needed services. If LGBT seniors avoid service providers because they feel misunderstood and unwelcome, their health and well-being is compromised and it is likely that more drastic and expensive treatments and interventions will be necessary.

Rural elders face difficult transportation challenges. King County has several distinct types of rural regions: 1) towns such as Skykomish and Baring that can only be reached by traveling out of the county and then circling back in through the mountains; 2) islands such as Vashon and Maury; 3) and small towns such as Carnation, Duvall, and Black Diamond. For planning purposes the rural areas of King County are defined as East Rural, South Rural, and Vashon Island.

The number of older adults living in the three rural subregions of King County is 11,347, 11% of the total rural population of 101,369. Vashon and Maury Islands have 1,825 adults 60 years of age and older, 18% of the total population of 10,123. The South Rural region, including Enumclaw, Black Diamond, and Maple Valley, has a 60+ population of 5,959, 12% of the total population of 49,337.

The East Rural region has a 60+ population of 3,563, 9% of the total population of 41,909. Towns in the East Rural region include: Duvall, Carnation, Issaquah, Snoqualmie, North Bend, Skykomish, and Baring.

[16] W. Keith Overstreet, "Urban American Indians: Myth, Stereotype, and Reality" 1999

The rural areas are situated in scenically lovely settings. The people living there, however, face significant barriers – particularly if they are 75 years of age or older, living alone and living on fixed incomes. 2000 census data indicates that there is a total of 1,331 people who are 75+ and living alone in the three rural areas of King County. Some of the low-income older people in these areas have no telephones, and others have no automobiles. The absence of these tools may further increase a person's isolation and vulnerability to emergencies. Furthermore, housing developers seldom consider rural areas for cost-effective projects, further limiting affordable and safe housing.

Many rural elders face difficulties getting to medical appointments or to outpatient clinics. According to the case managers who have clients in East Rural King County, most clients are driven to their medical appointments by their caregivers. There is limited public transportation in the rural areas. The King County Fire Department reports that older adults with needs that could be treated on an outpatient basis in clinics will instead call the Fire Department because of lack of transportation. The Fire Department crew will assess the person to determine the need, and if necessary will transport the person to the outpatient clinic or the pharmacy.

Goal

To address the basic needs of older adults and people with disabilities in the community**.**

Objectives

Affordable Housing

1. Secure affordable housing for 75 older people or adults with disabilities. (December 2007)
   - Obtain new Section 8 vouchers for 75 case management clients.

Mobility

2. Increase by 100 the number of older people and adults with disabilities who access rides via neighborhood shuttles. (December 2004) [2003 Baseline: In process]
   - Seek transportation funding to increase capacity of community shuttles throughout King County similar to the Des Moines, North Bend and Beacon Hill systems.
   - Convene regular key transportation partners to advocate for funds to coordinate transportation systems that serve mobility needs.
   - Seek additional transportation funding to increase capacity for Ride Options (formerly volunteer transportation)
   - Investigate potential for allowing yearly passes for ACCESS.

Accessing Appropriate Benefits and Services

3. Increase by 1,000 the number of older adults and their caregivers who are aware of appropriate benefits and services. (December 2004) (Total Benefits CheckUp and I&A 2002 Baseline: 8,048)
   - Advocate that the development of the new county-wide 2-1-1 system of access to information provide a seamless connection to the existing Information & Assistance (I&A) systems.
   - Translate education and outreach materials on 30 topics to inform limited/non–English speaking elders of service options. (2002 Baseline: 20 topics)
   - Make presentations in the community about the safe and appropriate use of prescription and nonprescription medications, manufacturer-sponsored prescription drug assistance programs, the Benefits CheckUp prescription drug discount eligibility screening capabilities, and offer assistance with completing application forms.

- Improve access to benefits and services for older adults who are deaf, hard of hearing and/or vision impaired.

4. Increase by 50 the number of Native American elders who access ADS-funded services. (December 2005) (2002 Baseline: 375)
   - Work in partnership with Native American community members to develop a best practices model that incorporates traditional roles of elders, intergenerational contact and connections, and accepts and respects traditional Indian family networks.
   - Develop a sustainable transportation program which meets the needs of Native American Elders in King County
   - Increase outreach and education to Native American communities.

5. Increase by 50 the number of Native American elders who participate in health and wellness activities at the senior congregate meal program. (December 2004) (2002 Baseline: 14)
   - Develop a culturally appropriate health and wellness component in the senior congregate meal program.

Rural Elders

6. Increase by 50 the number of rural elders who have access to transportation to services. (December 2004) (2002 Baseline: 224)

7. Increase by 50 the number of socially isolated rural elders referred to services. (December 2005) (2003 Baseline: In process)
   - Provide 10 Gatekeeper trainings per year in rural areas of King County.

8. Increase by 20 the number of affordable housing units with services to support aging in place in one rural area that has the greatest need. (December 2007) (2003 Baseline: In process)
   - Partner with non-profit developers to coordinate an affordable housing project with services.
   - Coordinate with housing organizations to promote more housing options for older people.

Community Indicators

- Percentage of people age 65+ who are aware of selected services in their community

- Percentage of rental housing that is affordable (Communities Count)

- Percentage of householders age 65+ in housing units with met/unmet home modification needs

- Percentage of people age 65+ who have access to public transportation

Health & Well Being

Background

The prevalence of chronic conditions is expected to increase over the next 25 years as life expectancy improves, the 60 and over cohort doubles, and the older population becomes more diverse. Although disability rates have decreased in recent years, the number of people with activity limitations is projected to increase. In addition the health effects of inequalities in the prevalence of risk factors and chronic conditions across ethnic groups and gender will increase in the coming years as a more diverse cohort ages.

There are many behavioral risk factors and preventive measures related to the leading causes of death, hospitalization, and disability. Studies show that preventive measures such as increasing physical activity, improving nutrition, reducing alcohol consumption, and utilizing health screenings and immunizations can help with managing chronic conditions and reducing associated disabilities as people age.

Women in King County have a life expectancy of 82.1 years compared to men whose life expectance is 77.5 years.

Chronic health conditions and activity limitations increase with age. In the year 2001, life expectancy at birth in King County reached an all time high of 79.9 years, higher than the national life expectancy of 77.2 years. Women in King County have a life expectancy of 82.1 years compared to men whose life expectancy is 77.5 years. Although the average life span is increasing, many older adults' quality of life is affected by disability or activity limitations due to physical, mental, or emotional conditions. Among King County older adults age 65 to 74, 23% had activity limitations. This percentage is even higher for those who are female, low-income, and 75 years of age and older.

Table 7. Percent of People Age 65+ With Activity Limitations Because of Physical, Mental, or Emotional Problems, King County 2001

Age	65 – 74	22.6%
	75+	36.1%
Gender	Male	25.5%
	Female	32.0%
AnnualHousehold Income	< $20,000	45.6%
	> $20,000	23.8%

Source: Behavioral Risk Factor Surveillance System, 2001

Some of the most prevalent chronic conditions related to disability among older persons in King County include hypertension, arthritis, severe vision or hearing impairment, mental health problems, diabetes, coronary heart disease, stroke, and asthma.

Table 8. 65+ Chronic Conditions Related to Disability King County, 2001

Hypertension	51.9%
Arthritis	42.6%
Severe Vision / Hearing Impairment	15.7%
Mental Health Problems	14.3%
Diabetes	14.3%
Coronary Heart Disease	12.7%
Stroke	7.1%
Asthma	5.2%

Source: Behavioral Risk Factor Surveillance System

Problems of mental illness and depression are increasing. Depression afflicts 10-20% of individuals age 65 and older. The fastest growing segments of older adults are also the most likely to experience stressors related to mental health problems. The very old, women, people of color, and people living alone have the highest rates of poverty, the poorest perceptions of health status, and the highest levels of activity limitations.[17] Immigrants and refugees whose language and cultural values differ from the mainstream culture are also at risk, because they often do not get services they need. Language, culture, lack of information, financial resources, and transportation difficulties present barriers for immigrant and refugee elders.

The onset of chronic illness for people 50 and over often leads to depression, the most common mental heath concern for older adults. "The presence of a chronic ailment is closely tied to functional capacity. Age and the presence and duration of chronic disease significantly decrease the ability to perform activities of daily living. Dependence on others in regard to shopping, bathing, and dressing has a negative impact on one's self-esteem and self-worth."[18]

Close to 90 % of depressed older patients in primary care get no treatment or inadequate treatment, despite the availability of effective treatment.

Almost 20 percent of older Americans experience mental disorders. Yet many primary care physicians are not trained to screen for mental illness, and, unfortunately, may attribute psychiatric symptoms to 'normal aging' or to chronic physical illness. As a result, close to 90 percent of depressed older patients in primary care get no treatment or inadequate treatment, despite the availability of effective treatments. Only 3 percent receive treatment for mental disorders from mental health specialist. [19]

[17] Sullivan, M. et.al. "Stepping Out on Faith: Geriatric Mental Health in 2015," *Project 2015: The Futhre of Aging in New York,* http://aging.state.ny.us/explore/project2015/artEld.pdf *, p. 111.*
[18] Sullivan, M. et.al., p. 112.
[19] The State of Aging and Health in America, The Merck Institute of Aging and Health, and The Gerontological Society of America, 2003.

Excessive consumption of alcohol and prescription drugs by older adults is often undetected. Older adults experience many changes, both physically and emotionally as they progress through the aging experience. Some will choose to self-medicate in attempts to block or dilute the negative aspects such as loss, physical disabilities, and loneliness. People with chronic, painful diseases such as arthritis, osteoporosis and cancer, or psychiatric disorders such as depression or anxiety, are more likely to drink or take substances[20]. Although one-half to two-thirds of older substance dependents were treated for alcoholism or addiction earlier in their lives, the remaining one-third began taking substances after the age of sixty[21]. Half of emergency room visits by older adults are due to consequences of alcohol or substance abuse[22].

When older people drink or take drugs, the effects can be significantly different than for younger adults. Older adults tend to need less alcohol to become intoxicated, and as many do not work, the effects do not interfere with social or job skills[23].

Treatments for older adults require individual approaches, in part to determine what triggers the need for the substance. Often, inpatient treatment is necessary in order to stabilize the medical or psychiatric conditions while the person's body clears itself from the substance [24]. Once the person moves back to the home, case management services are necessary to keeping the person stabilized and free of substances

Health disparities are increasing. Recent studies have shown that despite the steady improvements in the overall health of the United States, racial and ethnic minorities experience higher rates of morbidity and mortality than non-minorities[25]. "Health disparities are differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States."[26] Disparities in health care exist even when controlling for gender, condition, age and socio-economic status.

The two major factors contributing to health disparities for people of color are the health impacts of racism and differential treatment in the health care system. "Being on the receiving end of overt or subtle racism creates intense and constant stress, which boosts the risk of depression, anxiety, and anger – factors that can lead to or aggravate heart disease."[27] In addition to stress, studies show that racial and ethnic minorities receive a lower quality of health services even when controlling for income and insurance status. Even when they have access to care, racial and ethnic minorities experience a lower quality of health services and are less likely to receive routine medical procedures than non-minorities.

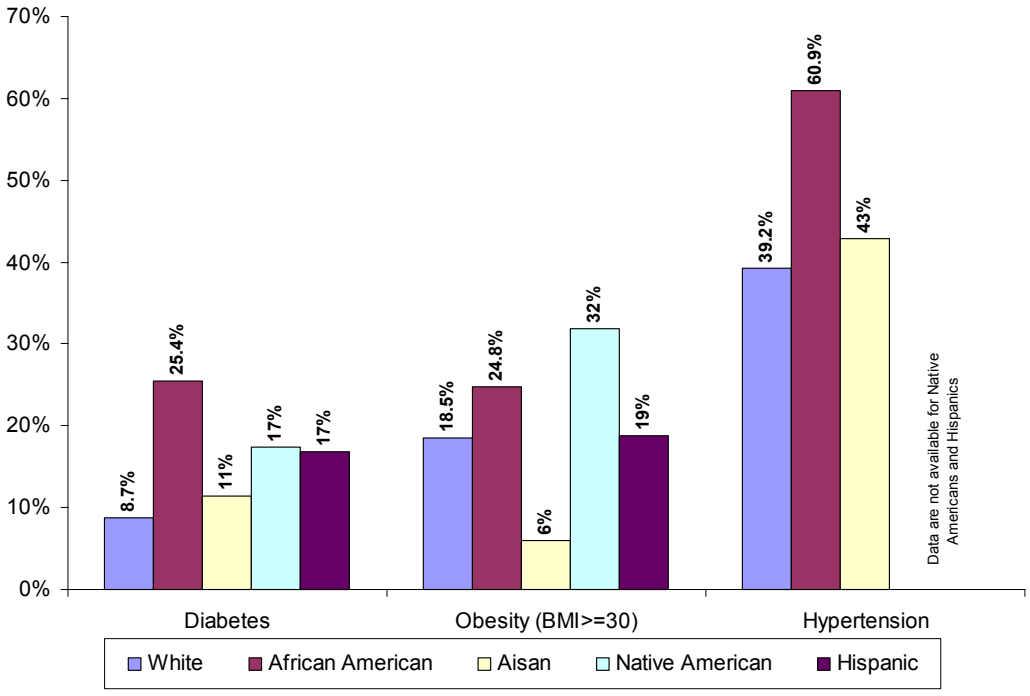
---

[20] Widlitz, Michelle and Marin, Deborah B. 2002. Substance abuse in older adults: An overview. Geriatrics, Volume 57 (12), p 29-34.
[21] Guiliano, 1986 and Atkinson, 1990
[22] (Zautcke JL, Coker, SB, et al, 2002).
[23] Widlitz, Michelle and Marin, Deborah B. 2002. Substance abuse in older adults: An overview. Geriatrics, Volume 57 (12), p 29-34.
[24] Irons, Richard and Rosen, Donald. 2000. Substance Abuse in the Elderly. Professional Renewal Center website: www.prckansas.org/articles.
[25] National Institute of Health, US DHHS, Health Resources Services Administration, Office of Minority Health, American Medical Association.
[26] Mayberry RM, Mili F, Ofili E. Racial and ethnic differences in access to medical care. *Med Care Res Rev*. 2000;57(Suppl 1):108-145.
[27] Kirchheimer, S. "Racism Should Be a Public Health Issue," Medscape, Jan. 9, 2003.

Health disparities persist as people age. In King County, there are pronounced disparities for people age 50 and older in the prevalence of the chronic conditions of diabetes and hypertension as well as the risk factor of obesity. The prevalence of diabetes (25.4%) and hypertension (60.9%) is highest for African Americans. Hispanic (17%), Native American (17%) , and Asian (11%) older adults also have a high prevalence of diabetes. Native Americans have the highest prevalence (32%) for the risk factor of obesity.

Access to primary care is limited in some areas. Across King County and Washington State, people with low incomes and those dependent on publicly-funded health care are finding it more and more difficult to find and maintain primary care. A recent survey of East King County physicians found that 48% of the Primary Care respondents are not accepting new Medicare patients, and 51% are not accepting any new Medicaid patients. The results of this survey concur with the Bellevue Needs Assessment which will be published in January 2004. Across King County, anecdotal evidence suggests that access to primary care is becoming an increasingly urgent issue. The 2003 Washington State Legislature approved more rigid eligibility requirements for Medicaid clients which are estimated to impact at least 700 clients statewide, and 175 (25%) in King County alone. In addition, several physician practices have resorted to charging a monthly premium in addition to Medicare rates and other insurances in order to remain solvent.

Figure. 6 The Prevalence of Diabetes, Obesity, and Hypertension Among King County Adults Age 50+ by Race/Ethnicity, 1999-2001



Source: BRFSS

Women experience worse health outcomes than men. As a result, women live more years with chronic conditions. The gender gap in health outcomes can be linked to differences in:

- Income: Women's wages are 70 percent of men's;
- Poverty: Women work fewer years due to caregiving, fewer receive pensions, and more live alone; and
- Increasing incidence of chronic conditions with advanced age: Women live 7 years longer than men on average.[28]

Behavioral risk factors are associated with chronic conditions. It is estimated that 70 percent of the physical decline that occurs with aging is related to modifiable risk factors. Overweight and obesity, physical inactivity, consuming excess amounts of alcohol, and poor nutrition are associated with 11 of the 13 leading causes of death, hospitalization, and disability.[29]

Table 9. Factors Related to the Leading Causes of Death, Hospitalization, and Disability

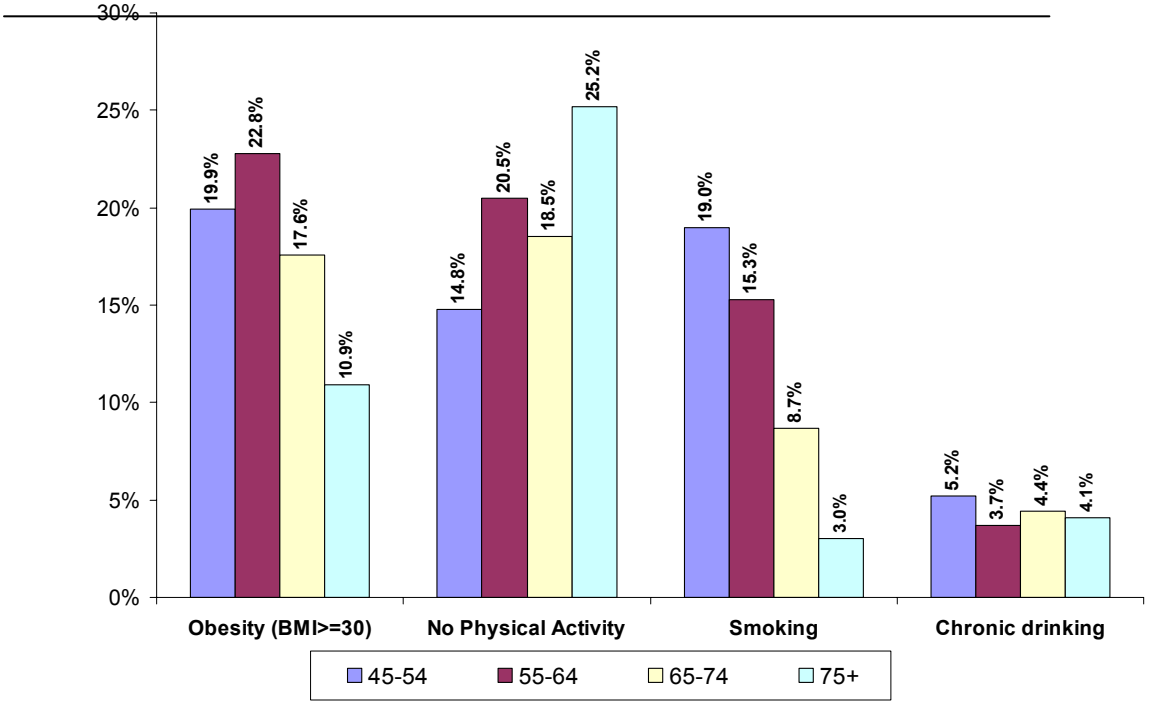
	Overweight and Obesity	Physical activity	Smoking	Alcohol	Nutrition	Flu shot	Pneumonia vaccination	Mammography	Sigmoidoscopy / colonoscopy
Heart Disease	X	X	X	X	X				
Cancer	X	X	X	X	X			X	X
Stroke	X	X	X	X	X				
Chronic lower respiratory disease		X	X			X	X		
Alzheimer's disease									
Influenza and pneumonia		X	X			X	X		
Diabetes	X	X			X				
Suicide		X		X					
Chronic liver disease				X					
Unintentional injuries									
Mental health		X		X					
Hypertension	X	X	X	X	X				
Arthritis		X							

[28] Meyer, M.H. "Gender, Generations, and Chronic Conditions," *the Public Policy and Aging Report,* Winter 2001.

[29] Holden, K. "Chronic and Disabling Conditions: The Economic Cost to Individuals and Society," *The Public Policy and Aging Report*. National Academy on an Aging Society, Winter 2001, volume 11, number 2.

Modifying these risk factors through education and health promotion activities is one promising method of reducing the incidence of chronic conditions and their associated disabilities and activity limitations.

Figure 7. Prevalence of Behavioral Risk Factors by Age, King County, 1999-2000



Source: BRFSS

Washington state has a higher incidence of food insecurity than the national average. Washington had poverty rates more than two percentage points below the national average, yet the prevalence of food insecurity was11.9 percent—well above the national average of 9.7 percent. [30] From 1995 through 1999, almost 1 in 20 (4.7%) of adults in King County are concerned about having enough food for themselves or their families, with Seattle having the highest rate of food insecurity (5.5%) and East King County the lowest rate (2.7%).[31] Another indicator of food insecurity is participation in the Basic Food Program, a critical source of nutrition assistance for low-income older adults in the U.S. One in five of the 7.3 million food stamp households in the U.S. are households headed by an adult age 60 and older.[32] While 88 percent of eligible children and 71 percent of adults under 60 apply for food stamps, only 29 percent of eligible older adults apply.[33] Low utilization by older adults in the Basic Food Program is of great concern in King County where poverty rates are increasing. Furthermore, poverty rates continue to be highest for people 65 years and older who are African American (17.7%), Multi-racial (17.2%), Asian (15.9%), and Hispanic (14.4%) compared with 5.6% poverty rate for people who are White.

[30] Nord, M., K. Jemison, and G.W. Bickel. 1999. Prevalence of Food Insecurity and Hunger by State, 1996-1998. Food and Nutrition Research Report No.2, USDA, Economic Research Service, Sept. 1999.
[31] Communities Count 2002: Social and Health Indicators Across King County, p.7.
[32] Gabor, Vivian et al. "Seniors Views of the Food Stamp Program and Ways to Improve Participation: Focus Group findings in Washington State," 2001.
[33] Castner, Laura and Scott Cody, Trends in FSP Participation Rates: Focus on September 1997", November 1999. http://www.fns.usda.gov/oane/MENU/Published/FSP/FILES/trends97.pdf

Long term care integration through disease self-management. Neither the medical care system nor the long term care system is yet stepping up to the task of chronic illness management despite increasing evidence of the quality of life and cost benefits of doing so. A number of successful chronic disease management programs have proven their efficacy and value,[34] but adoption of these approaches is not at all widespread. Behavioral counseling by physicians can be an effective disease management tool, but it is rarely offered.

The long term care system, too, has difficulty providing chronic disease management services. The continued segregation of funding for disease treatment (Medicare) from funding for supportive and palliative care over an extended period (Medicaid)—one of the symptoms of the lack of integration between the medical and long term care systems—is one of the major barriers.

Collaboration with public policy makers, consumer groups and service providers in the medical and long term care systems will provide opportunities for the aging network to develop integrated service delivery models to address such at risk populations who are suffering from various chronic diseases.

It may well be that, given its focus on the low income, frail and homebound population of elders and younger individuals with disabilities, the Aging Network in Washington may be able to bridge the gap by emphasizing chronic disease self-management and health behavior change. Incentives for integrating Medicare and Medicaid in this regard are strong and will only grow stronger with the aging of the baby boom generation. Further, conditions widely experienced by the population receiving aging network case management (i.e. diabetes, chronic obstructive pulmonary disease, and arthritis), represent the fastest-growing and highest-cost segment in healthcare.

The Aging and Disability Services approach to improve the health status of older adults and to reduce health disparities consists of:

- using evidence-based methods in services for older adults to improve nutrition, increase physical activity, and reduce symptoms of minor depression (e.g. The PEARLS Program);
- adding a chronic conditions management component to case management or other aging network programs with emphasis on self-management to improve chronic conditions and health outcomes (e.g. The Senior Wellness Program);
- remaining alert to opportunities to promote long term care integration through chronic disease management models (e.g. the Kin On Care Network; the ElderHealth Integrated Neighborhood Network, and the Elderplace PACE – Program of All Inclusive Care of the Elderly).

[34] AHRQ, *Preventing Disability in the Elderly with Chronic Disease*, April 2002.

Goal
To improve the physical and mental health and well being of older adults and people with disabilities.

Objectives

Disease Self-Management

1. Increase by 1000 the number of older people living in King County who are aware of disease prevention measures which they can take to reduce depression, improve nutrition, increase immunity to influenza, increase their physical activity, prevent falls, and stop overuse of alcohol and prescription drugs. (December 2005) (2002 Baseline: 1,200)
   - Participate in the Healthy Aging Partnership, a coalition of aging organizations sponsored by Public Health: Seattle-King County.
   - Create messages on nutrition, fall prevention, physical activity, immunization, depression, and recognizing the signs of misuse of alcohol and prescription drugs for radio and print media.
   - Sponsor one educational forum per year on health promotion for professionals in the aging field.
   - Sponsor one educational forum per year on health promotion for older adults.

2. Demonstrate how chronic conditions self-management by the aging network can reduce health care costs. (December 2007) (2004 Baseline: In process)
   - Seek funding for pilot projects that focus on prevention and self-management for frail, seniors residing in the community.
   - Investigate partnerships with the Seattle Parks and Recreation Department to develop recreational activities for homebound seniors.

3. Increase by 50 the number clients in the case management program whose chronic diseases are under control. Chronic diseases that will be targeted include diabetes, hypertension, heart disease, and chronic pulmonary obstructive disease. (December 2005) (2003 Baseline: In process)

   - Expand the chronic disease registry beyond clients with diabetes to include clients with heart disease, hypertension, and other chronic diseases.
   - Seek resources to expand the chronic disease registry and interventions to subcontracted case management agencies**,** targeting communities of color.
   - Increase the number of registry clients who receive medication monitoring, nutrition counseling, depression, and physical activity interventions.
   - Quantify medical cost savings for registry clients by connecting with Medical Assistance Administration payment information.

4. Increase by 500 the number of older adults who participate in regular physical activity. (December 2004) (2002 Baseline: 1,816)
   - Expand the Sound Steps walking program countywide.
   - Launch the SHAPE Seattle website that lists physical activity resources by neighborhood.
   - Add a walking component to the Farmers Market Program.
   - Partner with a local university to evaluate the effectiveness of the Sound Steps program on the ability to attract participants and on the impact of participation on the health and functional status of participants.
   - Promote HSD/ADS employee wellness education.

5. Increase by 30 the number of older adults whose symptoms of depressions and misuse of alcohol and prescription drugs are alleviated. (December 2005)
   - Increase participation in the PEARLS program or other similar program using a problem solving model specifically designed for older adults. (2002 Baseline: 69)
   - Seek funding to replicate the PEARLS model with limited English speaking refugees. (2002 Baseline: 0)
   - Increase by 60 the number of SHA residents who reduce depression using the PEARLS problem solving model. (2002 Baseline: 0)

6. Increase by 30 the number of refugee elders participating in culturally appropriate health promotion activities. (December 2004) (2002 Baseline: 130)
   - Partner with health promotion providers in refugee/immigrant communities to develop culturally appropriate activities.

7. Plan and coordinate a community summit on Healthy Aging with agencies involved in health promotion activities. (December 2004)

Nutrition

7. Increase by 300 the number of low-income older adults in the congregate meal program. (December 2005) (2002 Baseline: 4,046)

8. Increase by 200 the number of senior meal program participants who consume five servings of fruits and vegetables a day. (December 2005) (2002 Baseline: 1,450)
   - Seek funding to expand the Senior Farmer's Market program to 25% more meal program participants.
   - Pilot test new models such as the Harvest Lunch using locally grown produce to prepare congregate meals.
   - Pilot test intergenerational gardening at a meal site to increase fresh produce used in preparing congregate meals.
   - Partner with a local university to evaluate the effectiveness of the congregate meal program's ability to attract participants and on the impact of participation on the health and nutritional status of participants.

Community Indicators

- Percentage of people 65+ whose physical or mental health interfered with their activities in the past month
- Percentage of people age 65+ who report cutting the size of or skipping meals due to lack of money
- Percentage of people 65+ who participate in regular physical exercise
- Percentage of people age 65+ who report being in good to excellent health

Civic and Social Engagement

Background

In his groundbreaking work Bowling Alone, Robert Putnam, Professor of Public Policy at Harvard, documents a dramatic loss of "social capital" in the US. [35] Social capital refers to "the collective value of all 'social networks' (who people know) and the inclinations that arise from these networks to do things for each other ('norms of reciprocity')."

One of the major reasons for this decline is simply a lack of time. With longer working hours and the entrance of more women into the workforce, fewer people have the time to join social clubs and civic organizations. Retirees are an exception to this trend – the US has a growing population of talented, healthy, committed older adults who have the time necessary to address serious community issues.

Yet older people are not often encouraged to participate in community life. Just the opposite – many are enticed into bland "retirement communities" promoting a type of withdrawal from society. The more seniors are walled off from society in this manner, the more likely they are to vote based on narrow self-interest. If this age segregation continues to increase, intergenerational tension is bound to increase as well. Ugly "greedy geezers" stereotypes could re-emerge as the baby boomers retire in large numbers.

Community engagement is an important aspect of retirement. Retirement is often portrayed solely as a time of disengagement from society: a chance to travel, play golf or write memoirs. And not surprisingly most people look forward to some well-deserved leisure time after years of 40-hour-plus work weeks. But in retirement many older people find a jarring transition from productivity to idleness, from connectedness to isolation.

A new vision of retirement is emerging that takes a more balanced view. It recognizes that retirement is a time for leisure and reflection, but it can also be a time for active engagement in community life, through paid employment or volunteer commitments. This vision recognizes that most people can expect to live up to 20 years after retirement – almost a quarter of their lives. Most of these years will not be spent in nursing homes (where only about 5% of older adults live) or otherwise incapacitated. In fact 60% of older adults report no disability whatsoever[36], and rates of disability have been decreasing dramatically for this population. Each generation of retirees has been healthier, wealthier, better educated, and longer-lived than the one that preceded it.[37]

This new vision recognizes that remaining active in the community is beneficial to older adults. Several studies have shown strong correlations between social activity and improved health and well-being.[38] Finally – and perhaps most importantly – this new vision recognizes that older people have tremendous talents to contribute to society. It has been said that older adults, with their wealth of experience and talent, represent our only *increasing* natural resource.

---

[35] Putman, R. *Bowling Alone,* New York: Public Affairs, 2000.
[36] Census 2000, PCT26
[37] Freedman, M. *Prime Time: How Baby Boomers Will Revolutionize Retirement and Transform America.* New York: Public Affiars, 1999.
[38] Mendes de Leon, Carlos F., Glass, Thomas A., Berkman, Lisa F. "Social Engagement and Disability in a Community Population of Older Adults. The New Haven EPESE". *American Journal of Epidemiology* 2003; 157:633-642.

The built environment and universal design can promote community engagement. The way we build housing, roads, public buildings, and neighborhoods has a dramatic effect on community engagement, health, and well being. Smarter urban planning and building practices can decrease injuries and promote physical activity, one of the key risk factors for chronic disease. For older adults, staying physically active and socially engaged correlates strongly with improve health outcomes. Conversely, an isolated, sedentary lifestyle leads to depression, physical deterioration, and early death. Thus older adults can be expected to thrive in an environment that entices them outside, into public spaces that encourage social interaction – places where they can enjoy long walks and fresh air. The ideal environment will take into account their needs – frequent benches for resting and people-watching, crossing lights that allow for a slower pace, sidewalks that accommodate walkers and wheelchairs. [39]

Many design features of the built environment force older people into increased isolation. For instance, walking as a means of travel has declined over time due to distances among activities, communities that are not walkable, and the lack of sidewalks[40]. Americans make fewer than 6 percent of their daily trips on foot. Suburban neighborhoods are spread out with bigger houses on bigger lots, often within a cul-de-sac. In many cul-de-sac suburbs, sidewalks don't exist. Furthermore, single use zoning separates residential neighborhoods from jobs and shopping centers. Because cars are the mobility option of choice, roads are wide and busy. These same challenges create barriers for people of all ages.

As people age in place, their mobility and safety needs may change. Many common features of most homes (stairs, doorways, bathtubs, ovens) can present insurmountable barriers and safety risks when special needs arise or change in a person's life. Many times, it is the home itself that causes people to leave it, because it is no longer user friendly.[41] When architects and builders use universal design features, they increase the usability of the home by people of all ages, sizes, and abilities. Designing for a lifetime enhances the ability of all residents to live independently in their own homes for as long as possible. "Universal design anticipates diversity of ability and results in sensible, efficient, and realistic solutions for housing and streetscapes, buses and technology, and all other aspects of development…." [42]

Goal

To promote social and civic engagement of older people and adults with disabilities.

Objectives

Universal Design

1. Increase by 50 the number of universally designed public housing units built. (December 2005) (2002 Baseline: 0)
   - Partner with public housing authority architects and planners to educate developers and builders about housing designed for the lifespan.
   - Advocate that universal design principles be incorporated into public housing requirements.

---

[39] Howe, D. "Aging and Smart Growth: Building Aging-Sensitive Communities."
[40] Rosenbloom, S. "The Mobility of the Elderly," *Transportation in an Aging Society: Improving Mobility and Safety for Older Persons.* Washington D.C.: U.S. DOT, 1995.
[41] "Revitalizing Neighborhoods: Universal Design Housing", Center for Universal Design at North Carolina State University and AARP, www.njcrda.com/universaldesign.html, August 2003.
[42] Designing for the 21st Century, www.adaptiveenvironments.org/21century, August 2003.

2. Increase community awareness of universal design principles. (December 2007)
   - Build partnerships with architecture, design and urban planning programs at universities to promote aging-sensitive design principles into their curriculum.
   - Work with local media to showcase local design success stories.
   - Participate in county-wide Accessibility Home and Garden Tour and related educational forums.
   - Convene a task force (including senior centers) to further define objectives for social and civic engagement, including advocacy and social action.

3. Increase by two the number of neighborhood revitalization projects that include elder-sensitive design principles in their planning and policy documents. (December 2005) (2002 Baseline: 0)
   - Advocate for the “design charette” model of neighborhood planning to create pedestrian-friendly neighborhoods that improve physical activity, strengthen the sense of community, reduce car trips, improve access to community centers and other spaces (parks, libraries, gardens).
   - Build partnerships with planning departments to promote and offer incentives to developers for designs that will provide elder-friendly environments.
   - Build partnerships with key stakeholders to offer educational forums, workshops, or regular meetings in order to educate partners regarding the importance of active living by design across the life span.
   - Work with local media to educate seniors, groups and organizations about active living by design.

Engagement

4. Increase by 50 the number of seniors trained in "Seniors Training Seniors in Computer Basics" program. (December 2005) (2003 Baseline: In progress)
   - Recruit younger volunteers, such as high school students from Infotech Academies, to help refurbish donated computers.
   - Investigate ways to provide homebound elders with training and access to technology.

5. Increase by 100 the number of older adults who are actively engaged in community life, through paid employment or volunteer referrals. (December 2005) (2002 Baseline: 380 paid employment, 120 volunteer referrals)
   - Increase community awareness of positive aspects of aging by inviting national speakers to community discussions such as Town Hall and City Club.
   - Seek funding for a Life Options Center that will help older adults visualize healthy, active retirement options, and provide access to community resources in volunteering, healthy aging, continuing education, and employment -- a "one-stop shopping" center for retirement planning.
   - Ensure that the 211 system connects with volunteer opportunities for older adults.

Community Indicators

- Percentage of adults who are active in three or more life-enriching activities (Communities Count)

- Percentage of people age 65+ who volunteer

Independence for Frail Older Adults and People with Disabilities

Background

The majority of older adults want to remain in their homes with as much independence for as long as possible. Yet when chronic conditions lead to disability and limitations of activities, many people must rely on family or paid caregivers to provide assistance. Over 75 percent of caregivers are family members, who need support and respite themselves in order to continue in their caregiving role. The remaining 25 percent of people who need assistance to stay in their homes, receive care from paid home care workers. The stresses of caregiving, whether by family members or paid workers, can lead to burnout and elder abuse. The needs of both caregiver and care recipient must be considered in program development that supports the independence of people with activity limitations wishing to remain in their homes. Adult Day Care, Adult Day Health, and Respite Care Services are existing programs that help family caregivers deal with these issues.

Family caregiving. Caregivers are very diverse in the way they provide care and the impact the caregiving experience has on their health and well being. "The types and intensity of tasks that caregivers perform vary dramatically, depending upon the familial role of the caregiver. Evidence suggests that familial roles also influence how care is provided. The variability in caregiving behaviors indicates that the caregiving experience is significantly different for different types of caregivers… Some family members thrive, some simply survive, and others suffer severe consequences."[43]

Caregiving can take a heavy toll on caregivers, jeopardizing their health and emotional well-being. Millions of caregivers are spouses, siblings, or children who are in their seventies and eighties themselves. The physical demands, emotional distress, and their advanced age increase their risk for health problems. As a result, It is important to treat the caregiver as well as the receiver of care, because caregivers often do not seek medical care nor healthy activities for themselves. Since they are so involved in caregiving activities, caregivers are often unaware that services exist. They may only seek help when a crisis occurs.

Understanding the diversity in the caregiving experience can help guide the design and targeting of support services for caregivers. Their receptiveness to services shifts as they move through the seven caregiving stages: [44]

a. performance of initial caregiving task
b. self-definition as a caregiver
c. provision of personal care
d. seeking out or using assistive services
e. consideration of institutionalization
f. actual out-of-home placement
g. termination of the caregiver role.

The order and timing of these stages can help in the design and implementation of caregiver support programs. It is important to create multiple, flexible services that meet a wide range of caregiver needs and to recognize that caregivers use services only when they see the benefits outweighing the monetary, emotional, or physical costs of using services.

[43] Montgomery, R.J. & Kosloski, K.D. "Change, Continuity and Diversity Among Caregivers," Sept 2001.
[44] Ibid.

Elder abuse. Elder abuse can include physical aggression and beatings, psychological/emotional trauma (such as being isolated from others or being severely criticized), sexual, and financial exploitation. Nationwide, some estimates are that between 3 and 4 percent of the aging population have been abused or neglected. Other professionals stress that those numbers are too low, as many cases of abuse and neglect are believed to be unreported. Neglect can be defined as the failure of a caretaker to provide goods or services necessary to avoid physical harm, mental anguish or mental illness, for example, abandonment, denial of food or health related services. [45]

One complicating factor in determining abuse is the differing views by ethnic groups. For example, one study showed that African American, Korean American, and European American older females used different criteria in deciding whether scenarios they read fit the definition of abuse. These differences may pose problems when Adult Protective Services or Ombudsman staff use one form of criteria to assess abuse while people from other cultures use a different set of criteria.[46]

Older adults with dementia need long-term care options. Dementia is a disease of the brain, and Alzheimer's disease is the most common form. People with Alzheimer's disease have increasing trouble recalling information and learning any new information. The disease is progressive and the people affected by it ultimately become totally dependent on caregivers in order to survive. [47] An estimated 4.5 million Americans have Alzheimer's disease, with approximately 40,000 living in the Puget Sound area.[48]

One in 10 people over the age of 65 and nearly one in two people over age 85 have Alzheimer's disease or another form of dementia. A person with Alzheimer's disease will live an average of eight years, and some will live more than 20 years from the beginning of the disease. More than seventy percent of people with Alzheimer's disease live at home, usually cared for by family and friends. Medicare and most private health insurance do not cover the long term care that most people with dementia require. The average lifetime cost per patient is $174,000. By the year 2050, unless a cure is found, an estimated 13.2 million Americans will have Alzheimer's disease.[49]

Home Care Quality. Over 5,000 older adults and adults with disabilities receive home care through the Aging network in King County each year. Wages for workers rose by a modest amount of $1.75 per hour between 2000 and 2003, bringing the wage level to $8.43.

Aging and Disability Services faces several challenges in its oversight role for home care services in King County. First, the growing number of new home care agencies in King County has increased the oversight required by ADS. New agencies in particular create an extra monitoring workload due to the effort required to assist agencies with startup activities, recording keeping, and training requirements. Currently, ADS provides ongoing monitoring and oversight, as well as annual assessments for 18 home care agency contracts.

---

[45] Administration on Aging, *Fact Sheets, Elder Abuse Prevention.*

[46] Moon, R.H., and Williams, O. (1993). Perceptions of elder abuse and help-seeking patters among African-American, Caucasian American, and Korean-American elderly women. The Gerontologist, 33, 386-305. National Aging Resource Center of Elder Abuse. (1990). Elder abuse and neglect: A synthesis of research. Washington, DC: John C. Cavanaugh.

[47] The Merck Manual of Geriatrics, 1990, pages 934 – 935.

[48] Alzheimer's Association, http://www.alz.org/AboutAD/Statistics.

[49] Ibid.

Second, there continue to be home care worker shortages in East Urban and East Rural King County due to the high cost of living and the lack of transportation options to transport workers to the area. Low wages often mean that workers cannot afford their own vehicles. Many paid workers depend on public transportation, and for those providing in-home care to rural clients, traveling to and from remote locations is especially problematic.

Finally, communication between case managers and home care agencies regarding client referral, worker assignment, start dates, and gaps in service can be difficult given the volume of referrals and worker turnover. The use of technology to better connect case managers with home care agencies can improve the overall quality of service provided to clients.

Goal

To offer services which increase the independence of frail older adults and adults with disabilities.

Objectives

Family Caregiving

1. Increase by 1000 the number of family caregivers who receive supportive information that guides their long term care choices. (December 2005) (2004 Baseline: Tract the number of caregivers who receive information)
   - Conduct physician outreach to identify at-risk caregivers
   - Facilitate the discussion of "caregiver burden" health indicators between physicians and caregivers in order to assist caregivers to obtain access to services
   - Inform Developmental Disabilities network about the availability of family caregiver support resources.
   - Develop a pilot program for caregiver education in the work place.
   - Investigate the use of evidence-based tools for reaching family caregivers.

2. Increase by 50 the number of family caregivers whose burden is reduced by increasing flexible service options. (December 2005) (2003 Baseline: In process)
   - Replicate the supplemental services pilot based upon the outcomes of an evaluation of caregiver services and flexible service options.
   - Facilitate partnerships between high school service learning institutes and faith-based communities and caregivers

3. Increase by 50 the number of people from Latino communities who access family caregiver resources. (December 2004) (2003 Baseline: In process)

4. Advocate to increase funding in the state and Older Americans Act for family caregiver support, counseling, and peer support. (December 2005)

Case Management Services

5. Increase by $500 Amy Wong Client funding for needs of case management clients who are under 60 years of age. (December 2004) (2002 Baseline: $2,500)
   - Explore possibilities for extended after hour and weekend availability of case management, and Information & Assistance.

System and Quality Improvements

6. Convene quarterly information-sharing sessions for representatives of the Developmental Disabilities and Aging networks. (December 2004)

7. Investigate possibilities for increasing the availability of case management and Information and Assistance. (December 2005)

8. Increase worker wages by $1.00 per hour. (December 2005) (2003 Baseline: $8.43)
   - Advocate for increased worker wages and benefits in accordance with a livable wage standard.
   - Work with Advisory Council and community partners to sponsor a Legislative Forum with key legislators invited.

9. Increase by 35 the number of agency home care workers available in East Urban and East Rural King County. (December 2005) (2002 Baseline: 75)
   - Investigate transportation options that will increase agency worker availability in East Urban and East Rural King County

10. .Increase the home care referral acceptance rate. (December 2007) (2003 Baseline: In process)
    - Increase case manager utilization of the Home Care Referral system to formalize the start dates of home care services and to improve coordination between case management and home care agencies.
    - Incorporate language in home care contracts requiring written confirmation of accepted referrals.

Elder Abuse

11. Increase the number of referrals by gatekeepers to Adult Protective Services. (December 2005) (2002 Baseline: In process)
    - Enhance gatekeeper system that will provide training to bus drivers, faith-based, rural and neighborhood communities and business, on signs of abuse and resources on where to report suspected abuse.
    - Provide training to older adults on warning signs of escalating and potentially abusive situations.
    - Provide training to older adults on where to turn for help in times of abusive situations.
    - Distribute pamphlets describing assistance available through Senior I&A and the Crisis Clinic

Community Indicators

- Percentage of people age 65+ with adequate assistance in activities of daily living

- Percentage of people who have someone to help them if they are homebound (Communities Count)

AREA PLAN BUDGET
2004 ESTIMATED REVENUE

FEDERAL FUNDS	
Older Americans Act (OAA)	
-Title III-B, C, D, E, Elder Abuse	$5,037,504
-Title V (Employment)	$285,754
Total OAA	**$5,323,258**
Medicaid (Title XIX)	
Title XIX (Day Health Admin.)	$16,800
Personal Care, COPES, Case Mgmt. & Nurse Services & Contract Mgmt	$39,005,622
Title XIX Admin. Claiming	$900,454
Total Medicaid	**$39,922,876**
Other Federal Resources	
USDA	$500,000
Senior Farmers Market Nutrition Pilot Pragram	$85,000
Office Refugee Resettlement	$70,213
Center for Disease Control	$12,000
Orientation	$97,573
Basic Health Plan Premium	2,655,245
Traiing & Training Wages	716,107
Seattle King Public Health	18,371
Total Other Federal	**$4,154,509**
TOTAL FEDERAL FUNDS	**$49,400,643**

STATE FUNDS	
Sr. Citizens Services Act	$2,256,963
State Respite Care	$729,801
State Caregivers' Suppot	$175,243
Office of Attorney General	$262,137
Chore	$180,000
TOTAL STATE FUNDS	**$3,604,144**
LOCAL FUNDS	
City of Seattle	
General/Human Services Program	$1,509,411
Community Development Block Grant	$372,630
Combined Utilities	$973,685
Total City of Seattle Funds	**$2,855,726**
Other Local	
Contribution, fees, donations	$2,454,675
Seattle Housing Authority	$339,806
Providence Elder Place	$58,164
Total Other Local Funds	**$2,852,645**
TOTAL LOCAL FUNDS	**$5,708,371**

GRAND TOTAL $58,713,158

Aging and Disability Services 2004 Allocations

Service Area	2004 Base Allocations
Adult Day Services	
Discretionary	272,334
Non-Discr. Funding	37,145
Total Div. Funding	309,479
Agency Chore Personal Care	
Discretionary $	
Non-Discr. Funding	180,000
Total Div. Funding	180,000
Agency COPES & Medicaid Personal Care	
Discretionary $	
Non-Discr. Funding	30,992,191
Total Div. Funding	30,992,191
Alzheimer & Dementia Support Center	
Discretionary $	38,071
Non-Discr. Funding	
Total Div. Funding	38,071
Amy Wong Client Fund (formerly called Client Specific Funding Project)	
Discretionary $	325,243
Non-Discr. Funding	94,206
Total Div. Funding	419,449
Agency Homecare Workers' Health Plan Premiums	
Discretionary $	
Non-Discr. Funding	2,664,659
Total Div. Funding	2,664,659
Case Management	
Discretionary $	1,222,521
Non-Discr. Funding	7,393,217
Total Div. Funding	8,615,738
Day Health Certification and Re-certification	
Discretionary $	
Non-Discr. Funding	14,600
Total Div. Funding	14,600
Depression Study (PEARLS project)	
Discretionary $	
Non-Discr. Funding	8,065
Total Div. Funding	8,065
Disability Access and Information & Referral	
Discretionary $	104,124
Non-Discr. Funding	
Total Div. Funding	104,124

Aging and Disability Services 2004 Allocations

Service Area	2004 Base Allocations
Family Caregiver Support Services	
Discretionary $	
Non-Discr. Funding	776,452
Total Div. Funding	776,452
Health Maintenance/Health Professional	
Discretionary $	59,340
Non-Discr. Funding	
Total Div. Funding	59,340
Health Pro./Disease Prev. Projects	
Discretionary $	104,360
Non-Discr. Funding	18,371
Total Div. Funding	122,731
Health Pro./Disease Prev. Projects for Medication Management	
Discretionary $	29,063
Non-Discr. Funding	
Total Div. Funding	29,063
Homesharing *	
Discretionary $	69,782
Non-Discr. Funding	
Total Div. Funding	69,782
Information & Assist. - Primary	
Discretionary $	958,994
Non-Discr. Funding	98,860
Total Div. Funding	1,057,854
Information & Assist.-Special	
Discretionary $	289,372
Non-Discr. Funding	246,791
Total Div. Funding	536,163
Legal Services	
Discretionary $	189,757
Non-Discr. Funding	
Total Div. Funding	189,757
LTCOP/Elder Abuse Prev.	
Discretionary $	77,305
Non-Discr. Funding	
Total Div. Funding	77,305
Mental Health	
Discretionary $	103,087
Non-Discr. Funding	
Total Div. Funding	103,087

Aging and Disability Services 2004 Allocations

Service Area	2004 Base Allocations
Nursing Services	
Discretionary $	
Non-Discr. Funding	1,013,582
Total Div. Funding	1,013,582
Nutrition - Congregate	
Discretionary $	1,470,538
Non-Discr. Funding	1,816,510
Total Div. Funding	3,287,048
Nutrition-Home Delivered	
Discretionary $	627,448
Non-Discr. Funding	965,942
Total Div. Funding	1,593,390
Nutrition-Outreach and Education	
Discretionary $	77,864
Non-Discr. Funding	
Total Div. Funding	77,864
Orientation of IP & Agency Workers	
Discretionary $	
Non-Discr. Funding	47,676
Total Div. Funding	47,676
Outreach Advocacy	
Discretionary $	243,101
Non-Discr. Funding	35,000
Total Div. Funding	278,101
Cultural Connection	
Discretionary $	
Non-Discr. Funding	48,341
Total Div. Funding	48,341
Respite Care	
Discretionary $	
Non-Discr. Funding	650,963
Total Div. Funding	650,963
Senior Centers	
Discretionary $	123,848
Non-Discr. Funding	
Total Div. Funding	123,848
Senior Community Service Employmt. Program--Title V	
Discretionary $	
Non-Discr. Funding	367,908
Total Div. Funding	367,908

Aging and Disability Services 2004 Allocations

Service Area	2004 Base Allocations
Senior Employment-Others	
Discretionary $	
Non-Discr. Funding	159,499
Total Div. Funding	159,499
Senior Farmers Market	
Discretionary $	
Non-Discr. Funding	259,832
Total Div. Funding	259,832
Seniors in Services	
Discretionary $	
Non-Discr. Funding	65,398
Total Div. Funding	65,398
Training Homecare workers	
Discretionary $	
Non-Discr. Funding	758,895
Total Div. Funding	758,895
Transportation-Nutrition	
Discretionary $	399,810
Non-Discr. Funding	
Total Div. Funding	399,810
Transportation-Volunteer	
Discretionary $	30,687
Non-Discr. Funding	36,120
Total Div. Funding	66,807
Technology Support	
Discretionary $	47,001
Non-Discr. Funding	
Total Div. Funding	47,001
Utility Discount Programs	
Discretionary $	
Non-Discr. Funding	932,241
Total Div. Funding	932,241
Coordination	
Discretionary $	380,000
Non-Discr. Funding	
Total Div. Funding	380,000
In Home Service Contract Mangement	
Discretionary $	17,500
Non-Discr. Funding	679,002
Total Div. Funding	696,502

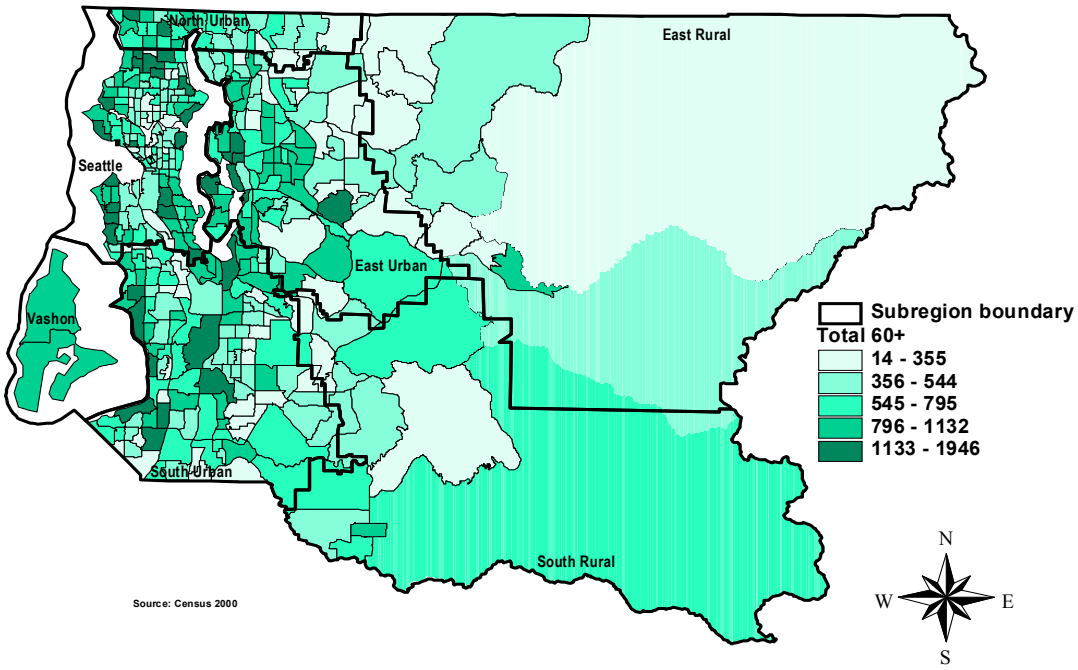
Aging and Disability Services 2004 Allocations

Service Area	2004 Base Allocations
Administration	
Discretionary $	805,141
Non-Discr. Funding	408,016
Total Div. Funding	1,213,157
Unobligated	
Discretionary $	50,661
Non-Discr. Funding	0
Total Div. Funding	50,661
Nutrition-Registered Dietitian	
Discretionary $	33,000
Non-Discr. Funding	0
Total Div. Funding	33,000
Total Discretionary	8,149,952
Total Non - Discretionary	50,769,482
Grand Total	**58,919,434**

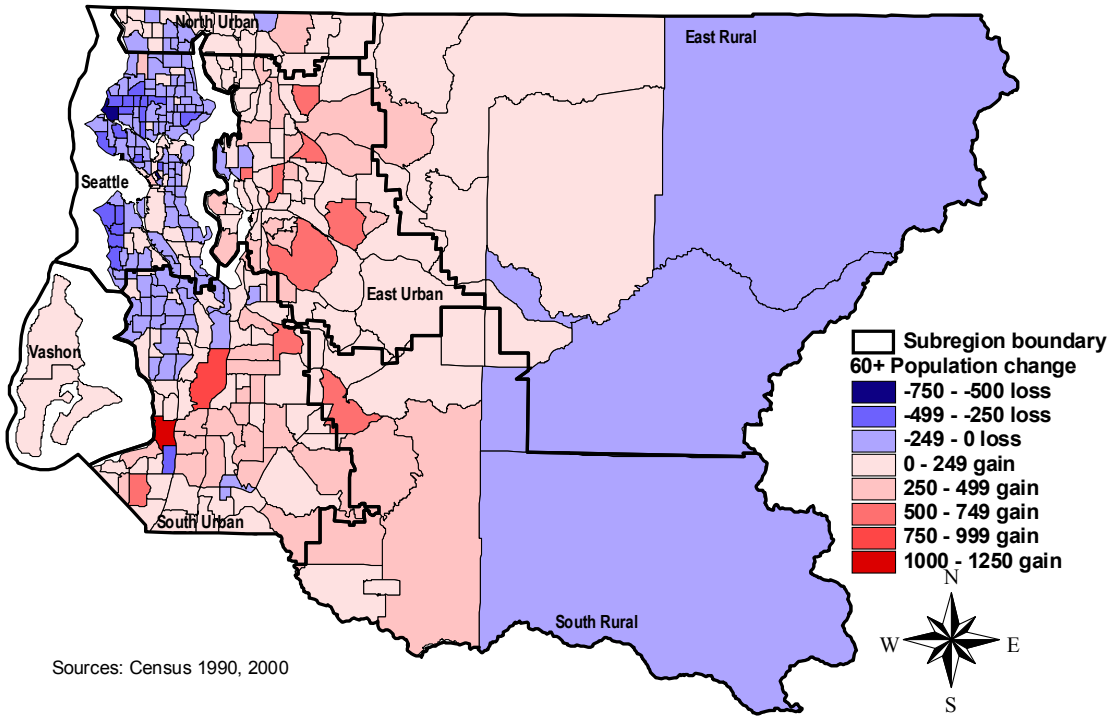
Appendices

Appendix A. Maps

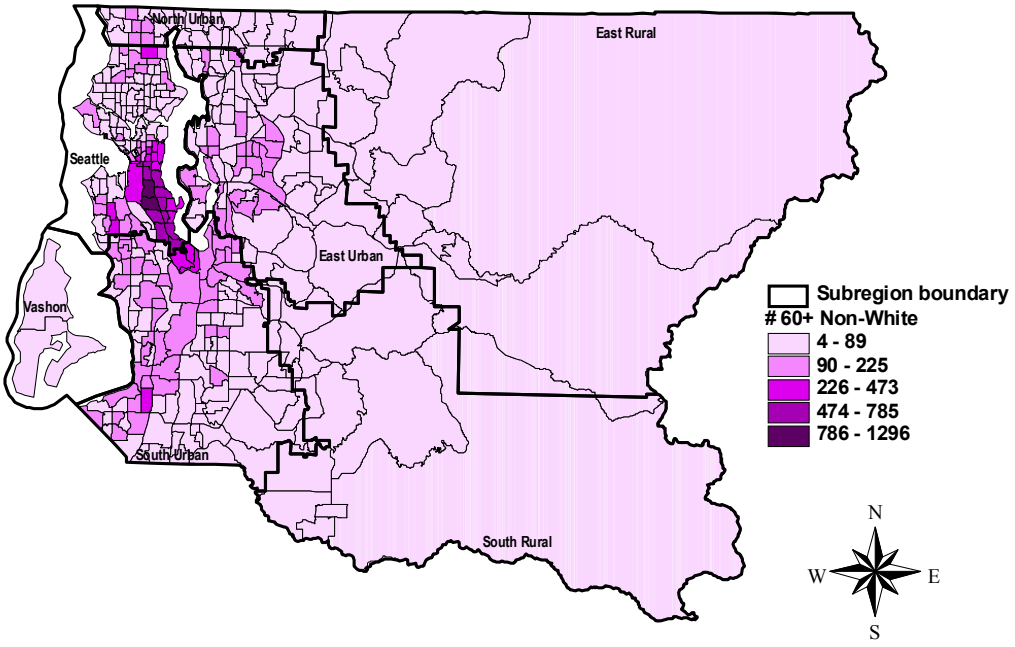
Map 1. Total 60+ Population, 2000



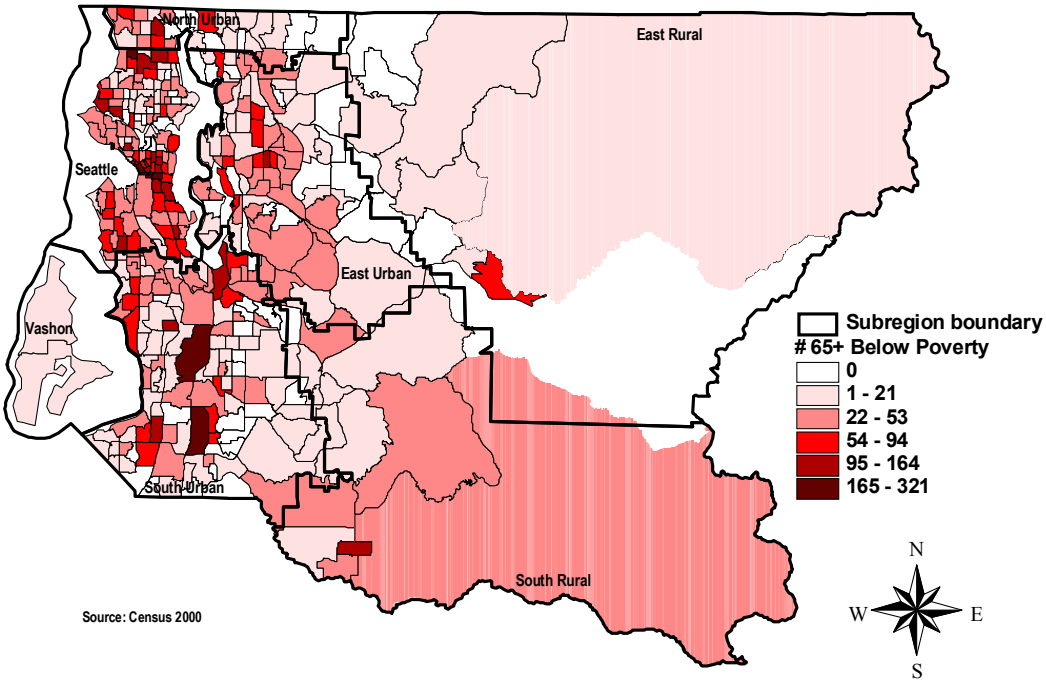
Map 2. Change in 60+ Population, 1990-2000



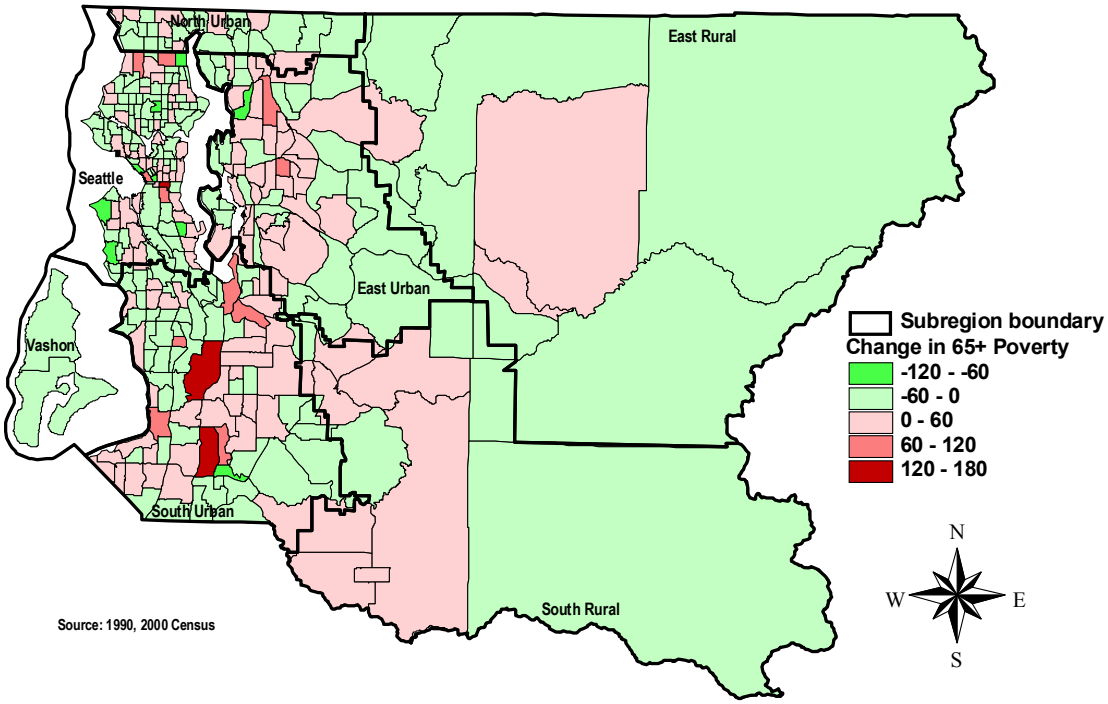
Map 3. 60+ Persons of Color



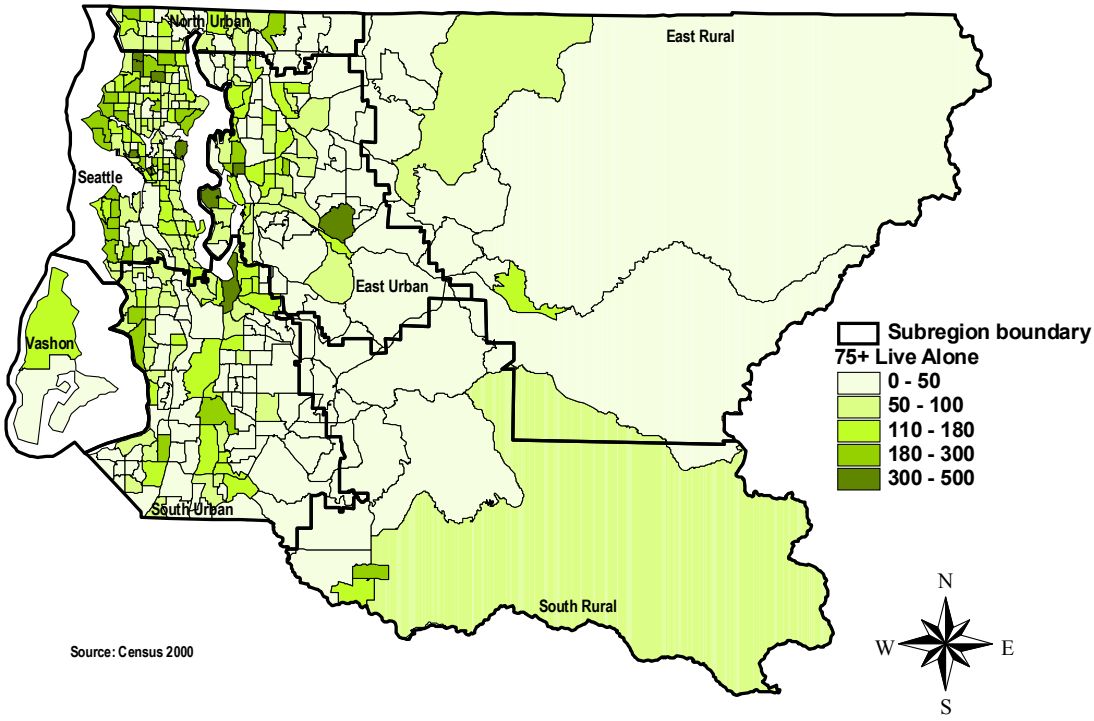
Map 4. 65+ Below Poverty



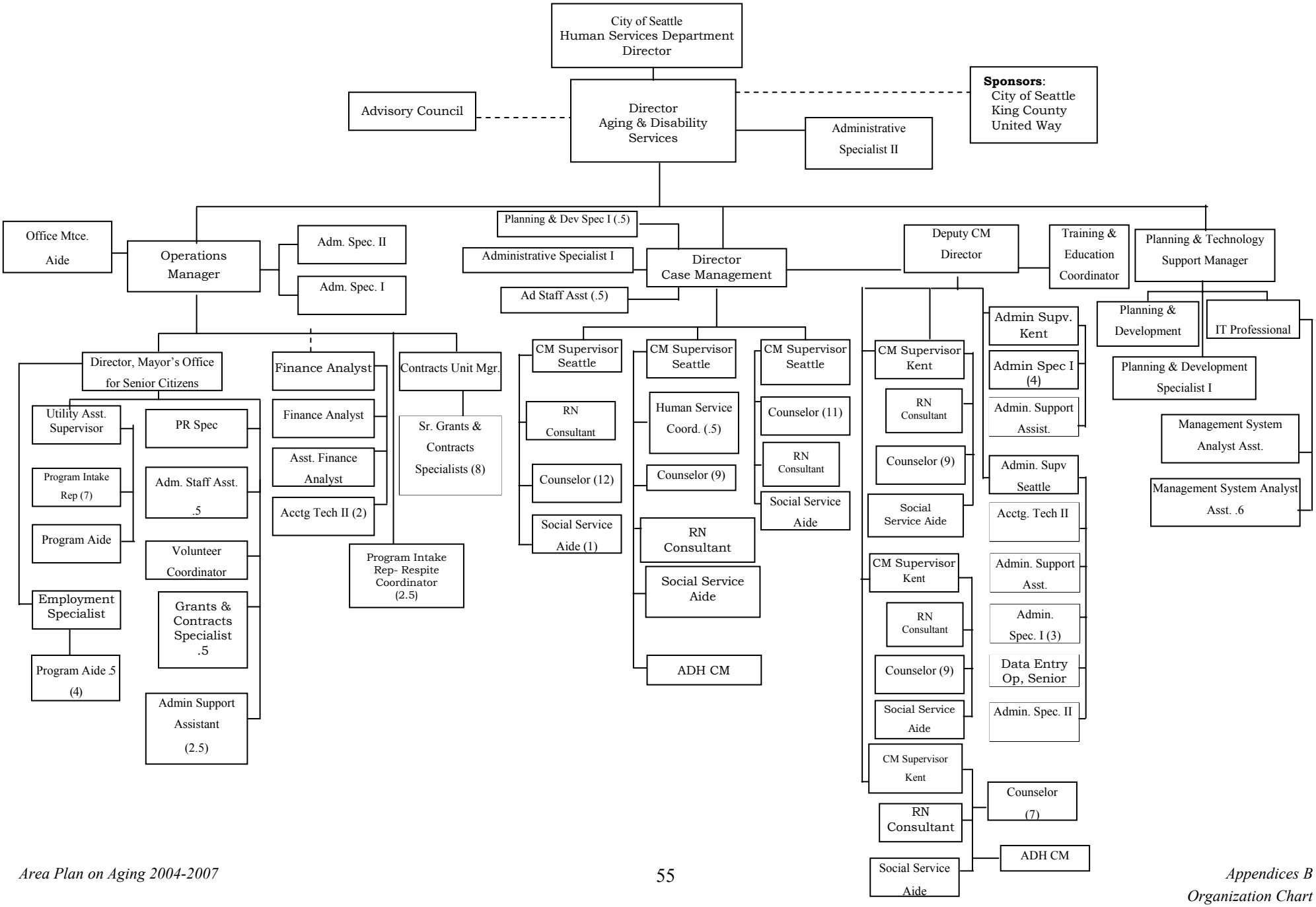
Map 5. Change in the Number of 65+ Residents Below Poverty, 1990-2000



Map 6. 75+ Residents Who Live Alone



Appendix B: Organizational Chart



Appendix C. Staffing Plan

POSITION TITLE	TOTAL STAFF (Full Time & Part Time)	POSITION DESCRIPTION
Planning & Administration		
Director	1 F/T	Directs and supervises all AAA activities.
Planning and Technology Manager	1 F/T	Oversees all planning functions and data systems.
Planning & Development Specialists II	3 F/T	Conduct planning functions: Area Plan development, systems coordination, advocacy.
Planning & Development Specialist I	1 F/T	Provides staff support to the Advisory Council on Aging and Disability Services, performs planning work.
Operations Manager	1 F/T	Oversees contracted services, agency budget, administrative support, and the Mayor's Office for Senior Citizens. Serves as the HIPAA Privacy Officer.
Contracts and Service Development Manager	1 FTE	Oversees all contracted services.
Sr. Grants & Contracts Specialists	8 FTE (10 staff)	Conduct program & contract monitoring, negotiation, training & technical assistance to subcontractors.
Respite Program Coordinator	2.5 FTE	Perform assessment and scheduling for Respite services.
Administrative Specialist II	2 FTE	One serves as assistant to AAA director; the other performs word processing, contract production, payroll coordination.
Accounting Technician II	2 FTE	Perform fiscal & budget management support.
Administrative Specialist I	1 FTE	Provides administrative support.
Finance Analyst	2 FTE	Perform fiscal and budget management.
Finance Analyst, Asst.	1 FTE	Assists the Finance Analyst.
Office/Maintenance Aide	0.5 FTE	Provides clerical support (from the Supported Employment Program).
Management Systems Analyst, Asst.	3 FTE	Perform computer programming.
Case Management Program		
Case Management Program Director	1 FTE	Directs the in-house Case Management Program, serves as disaster coordinator.
Case Management Deputy Director	1 FTE	Supervises Kent Case Management Teams & administrative support.
CM Team Supervisor	6 FTE	Each supervises a team of case managers.
Case Manager	55.3 FTE (59 staff)	Provide case management services to in home clients; conduct Day Health assessment; one serves as Fair Hearing Coordinator.
Registered Nurse Consultant	6 FTE	Serve as nurse consultants to the case managers.
Administrative Specialist I	7 FTE	Provide administrative support.
Administrative Specialist II	1 FTE	Provides administrative support.
Administrative Supervisor	2 FTE	Supervise administrative support staff.

Staffing Plan

Administrative Support Assistant	2 FTE	Provide administrative support.
Data Entry Operator, Sr.	1 FTE	Performs data entry for SSPS.
Accounting Technician II	1 FTE	Provides fiscal support.
Social Service Aide	6 FTE	Provide support to case managers.
Planning & Dev. Spec. I	0.5 FTE	Performs operational planning.
Admin. Staff Asst.	0.5 FTE	Coordinates hiring processes.
Human Service Coordinator	0.5 FTE	Coordinates chronic disease management.
Training & Education Coordinator	1 FTE	Provides and coordinates training for CM staff.
Mayor's Office for Senior Citizens		
Director, MOSC	1 FTE	Directs all activities of the MOSC.
Administrative Staff Assistant	0.5 FTE	Performs budget management, coordinates office operation, and payroll.
Employment Specialist	1 FTE	Supervises the Employment Resource Center.
Public Relations Specialist	1 FTE	Coordinates all public information and special events.
Volunteer Coordinator	1 FTE	Coordinates the Seniors (and others) in Service to Seattle program.
Grants and Contracts Spec.	0.5 FTE	Coordinates the Title V grant and contracting with host agencies.
Utility Rate Program Supervisor	1 FTE	Supervises the Rate Assistance Programs and Project Share.
Program Intake Representative	7 FTE	Process client application and enrollment for the Utility Rate Assistance program and Project Share.
Administrative Support Assistant	2.5 FTE	Provide front desk reception and other clerical support. One performs admin. Support for the Employment unit.
Program Aide	2 FTE (4 staff)	Provide employment counseling services.
Program Aide	1 FTE	Provides administrative and data entry support.

Total Number of full time equivalent	140.3
Total number of staff positions	152
Total number of ethnic minority staff	55
Total number of staff over age 60	12
Total number of staff indicating a disability	5

Appendix D

The Advisory Council on Aging and Disability Services (ADS) is a 27-member citizens body mandated by the Older Americans Act of 1965. The Council has a significant role in guiding Aging and Disability Services as it administers services for older people in King County.

Sponsors of ADS and its Advisory Council are:

City of Seattle **King County** **United Way of King County**

The Advisory Council accomplishes its work mainly through its committees and task forces:

- Health Care
- Outreach & Legislative Advocacy
- Planning and Allocations

Listed by appointing authority are the current 20 members of the Advisory Council:

City of Seattle

Joanne Brekke
Thelma Coney
Cleo Corcoran
Adam John
John Kennedy
Yolanda Sanchez-Lovato
Larry Low
Richard McIver*
Alexandra Tu

King County

Gabriel Cohen
Steve Colwell
John Holecek
Helen M. Spencer
Larry Verhei
Lisa Yeager

United Way of King County

Marc Avni
Martha Becker
Timmie Faghin
Will Parry
Suzanne Wiley

* - Elected official

Total Age 60 Years of Age or Over:	12
Total People of Color:	5
Total Self-Indicating a Disability:	2

Appendix E. Public Comment Summary

Comments received regarding the Area Plan 2004-2007 are summarized below. Highlighted also are changes made to the draft plan as a result of the comments. Overall, the comments about the plan were very positive. Many individuals expressed appreciation for a well written, forward thinking, and informative plan with very useful demographic information regarding older and people with disabilities.

	Comments and Rationale	YES Page #	NO	Area Plan Additions/Comments
DEMOGRAPHICS	The demographic data section is excellent, and aging organizations will use it to answer questions from the public more easily.		X	**Response**: Affirms efforts to profile older adults and adults with disabilities in King County.
	The Area Plan should include a discussion of the needs of the older adults who are deaf and hard of hearing.	26		**Response**: Add bullet to objective #3 to read: Improve access to benefits and services for older adults who are deaf, hard of hearing and/or vision impaired.
BASIC NEEDS	ADS should work with housing organizations like the ARCH to promote more housing options for older people, such as accessory dwelling units.	23		
	The Area Plan should include a description of the Rainbow Train, as well as a discussion of the needs of Lesbian, Gay, Bi-Sexual, and Transgender elders, and increasing services to this population.	X		**Response**: Will be included in the Basic needs section.
	ADS should advocate for yearly passes to replace monthly passes for ACCESS riders.	25		

Public Comment Summary

	Comments and Rationale	YES Page #	NO	Area Plan Additions/Comments
BASIC NEEDS Continued	ADS should continue efforts to disseminate information to older adults regarding services provided through the aging network.		X	**Rationale**: Affirms current efforts related to Information and Assistance on pages 23 to 24.
	ADS should emphasize that it provides services county-wide. Many county residents think ADS services only apply to Seattle residents.	Title Page		**Response**: The Area Plan title will include tag line *"Creating choices for elders and adults with disabilities in Seattle-King County".*
	While the BenefitsCheckUp Tool is helpful in identifying services/programs for which individuals are eligible, the Area Plan objective should also aim to provide assistance with completing application forms, such as the prescription drug discount program applications.	26		
	The Area Plan should include definitions for low-income and affordable housing, in order to educate readers about the differences.		X	**Rationale**: ADS will research this issue and include a discussion in the 2006 Area Plan Update if appropriate.
	ADS should encourage programs to take into account the needs of rural elders who are land-rich, but cash-poor.		X	**Rationale**: ADS will continue to give consideration to the needs of rural elders in program planning and service development.
	ADS should advocate for housing for seniors and disabled adults in Carnation, Duvall, and Fall City.	27		**Response**: This item will be considered when ADS addresses objective #8 in the Basic Needs section.

Public Comment Summary

	Comments and Rationale	YES Page #	NO	Area Plan Additions/Comments
HEALTH & WELL BEING	ADS should seek funding expand the Senior Farmer's Market program to include older adults in the Bothell and Northshore areas.	35		
	The Area Plan should highlight the effectiveness and outcomes of the PEARLS Depression Study.		X	**Rationale**: Initial results are included in the Area Plan Report Card. Full results will be available by Dec. 2003.
	ADS should continue advocating for coordinated systems and services for older adults with mental health issues.		X	Rationale: The 2004 allocations will begin to address mental health issues.
	The Area Plan should include Disease Management programs in order to help individuals learn the importance of self-manage their own diseases and health.		X	**Rationale**: Affirms current efforts related to Disease Management on pages 33 to 34.
	The Area Plan should include an objective to coordinate a summit on healthy aging in order to bring together different health promotion efforts underway with different agencies.	35		**Response**: Add to objective #4: ▪ Plan and coordinate a community summit on Healthy Aging with agencies involved in health promotion activities.
	ADS should include providers when coordinating health enhancement efforts, especially around planning programs for immigrants and communities of color, to ensure cultural relevance.	35		
	ADS should invest more resources in the Health Enhancement Program.		X	**Rationale**: This item will be considered by the Planning and Allocations Committee in 2005.

Public Comment Summary

	Comments and Rationale	YES Page #	NO	Area Plan Additions/Comments
HEALTH & WELL BEING Continued	ADS should promote recreational activities for homebound seniors and disabled adults though collaborative partnerships (e.g. Seattle Parks and Recreational Dept.)	34		**Response**: Add bullet under objective #2 to read: ▪ Investigate partnerships with Parks and Recreation Dept. to develop recreational activities for homebound seniors.
	The Area Plan should address the impact of dementia on older adults, especially among those 85 and older.	39		**Response**: Will include paragraph regarding dementia and older adults.
	The Area Plan should highlight the need for access to primary care, particularly for communities of color.	28		**Response**: Will add paragraph in Health & Well Being section, and an objective for the Advisory Council on page 34.
CIVIC & SOCIAL ENGAGEMT	ADS should increase intergenerational mentoring programs for computer training.	38		
	ADS should consider the role of Senior Centers when planning for a Life Options Center as a means to keep people connected with their communities, by encouraging advocacy, social action and civic engagement.	38		**Response**: Add bullet to objective #2: ▪ Convene a task force (including Senior Centers) to further define objectives for social and civic engagement, including advocacy and social action.
INDEPENDENCE FOR FRAIL & PEOPLE WITH DISABILITIES	ADS should continue to advocate for more funding for the Caregiver Support Program.	41		**Response**: Add objective #4: Advocate to increase funding in the state and Older Americans Act for family caregiver support, counseling, and peer support.

Public Comment Summary

	Comments and Rationale	YES Page #	NO	Area Plan Additions/Comments
INDEPENDENCE FOR FRAIL & PEOPLE WITH DISABILITIES Continued	The Area Plan should include a discussion of the needs of caregivers who are employed, and the impact the impact employment has on caregiving.	41		**Response**: Add bullet to objective #1: ▪ Develop a pilot program for caregiver education in the work place.
	ADS should increase efforts to educate caregivers about the network of aging services, and provide assistance with navigating through it.	41		**Response**: Revise objective #1 to read: Increase by 1000 the number of family caregivers who receive supportive information and assistance that guides their long term care choices. (Tract the number of caregivers who receive information and assistance)
	ADS should work with senior organizations to train bus drivers to be gatekeepers.	42		**Response**: Revise objective #9 to read: Enhance gatekeeper system that will provide training to bus drivers, faith-based, rural and neighborhood communities and business, on signs of abuse and resources on where to report suspected abuse.
	ADS should work to enhance funding for the Gatekeepers Program in order to provide training to bus drivers, in the rural, faith-based, neighborhood communities and businesses.		X	**Rationale**: The 2004 Discretionary Allocation recommendations includes increased funding.
	ADS should continue efforts to educate seniors, groups & organizations (YMCA, Parks, Engineers, etc) about the built environment and the importance of physical activity.	38		**Response**: Add bullet to objective #3: Work with local media to educate seniors, groups and organizations about active living by design.

Public Comment Summary

	Comments and Rationale	YES Page #	NO	Area Plan Additions/Comments
INDEPENDENCE FOR FRAIL & PEOPLE WITH DISABILITIES Continued	ADS should advocate for case management and Information and Assistance to be available 24 hours, seven days a week.	41		**Response**: Add objective #6 to read: Investigate possibilities for increasing the availability of case management and Information and Assistance.
	ADS should broaden the program definition for the Cash & Counseling Program to allow for more flexibility on how funds can be used (e.g. household emergencies).	41		**Response**: Revise objective #2 to read: Replicate the supplemental services pilot based upon the outcomes of an evaluation of caregiver services and flexible service options.
	The Area Plan should include evidenced-based tools for caregiving.	41		**Response**: Add bullet to objective #1: Investigate the use of evidence-based tools for reaching family caregivers.
	ADS should advocate for including family members on Medicaid in the "Powerful Tools for Caregivers" training.		X	**Response**: Will investigate the possibility of including Powerful Tools Training as a continuing education option for Medicaid personal care workers.
	ADS should continue to address issues regarding homecare quality.		X	**Rationale**: Addressed on page 40.
BUDGET	Since ADS intends to expand the PEARLS Program, ADS should consider changing the name for the PEARLS Depression Study to the PEARLS Program.	X		**Response**: In the 2004 Allocations Section, under Depression Study (PEARLS Project) the heading will be changed to PEARLS Program.

Public Comment Summary

	Comments and Rationale	YES Page #	NO	Area Plan Additions/Comments
2004 ALLOCATIONS	All States are instructed to include in their State Plan (or its amendments) objectives for implementing the five categories of the National Family Caregivers Support Program, Title III, Part E of the Older Americans Act and how it will be integrated into existing services supported but the Act.	X		**Response**: In the 2004 Allocations Section, under Family Caregiver Support Services, the following comments will be included: Funding in this area comes from Title IIIE of the Older Americans Act and state General Fund. While Title IIIE funds are listed as discretionary, they are earmarked for support to unpaid caregivers and kinship care. The breakdown of funding will be: Administration 10%; Information & Access, Counseling, Support Training 64%; Respite 3.4%; Supplemental Services 13%; and Kinship Care 9.2%.
GENERAL COMMENTS	ADS should improve accommodations for hearing and vision impaired older adults at all public meetings.			**Response:** The Advisory Council will investigate options for deaf and hard of hearing and vision impaired with the Hearing, Speech and Deafness Center.

Appendix F. 2000 – 2003 Area Plan Accomplishments

	Measures	2000	2001	2002	Projected 2003	2003 New Funds	Comments
	Healthy Aging						
	Increase health status of health promotion participants						
√	Refugees participating in health promotion	0	128	130	130	$ 125,000	ORIA grant
√	Number of people with access to transportation	2,971	3,108	3288	3300		Nutrition and volunteer
√	Grant funding to replicate Des Moines transportation model					$ 898,976	Mt. Si, Senior Services, Hopelink, Hyde Bequest
√	Metro funding for volunteer transportation program (senior shuttles)	$47,656	$64,955	$ 216,955	$ 342,399	$ 342,399	
√	Meal participants who eat more fruits & vegetables		540	965	1400	$ 85,000	USDA, Vitamin Settlement
√	Meal participants with incomes below 200% poverty	4,275	5,511	5842	6000		
√	Funding for natural medicine pilot					COPES	Bastyr University
√	New funds for Relatives Raising Children	$ -	$27,500	$ 61,000	$ 55,000	$ 55,000	
X	New intergenerational volunteers	70	142				Decreased City funding
	Increase awareness of disease prevention measures						
√	4Elders Website hits	4000	42,896	74,179	114,660		
√	Calls to 1-888-4Elders	1344	3,607	4,640	6,234		
	Increase diabetic clients with disease under control						
√	Number in Diabetes Registry	0	224	303	323		
√	**Increase clients whose symptoms of depression are lessened**			69	70		UW PEARLS research study

2000 – 2003 Area Plan Accomplishments

	Measures	2000	2001	2002	Projected 2003	2003 New Funds	Comments
	Long Term Care						
√	**Advocate for increased worker wages**	$6.68	$7.18	$7.68	$8.43		Wages rose $1.75/hour over 3 years.
√	Legislative Forums	1		1			
√	Advocacy Days	2	2	2			
	Increase length of time case management clients live at home.	19 months	21 months	24.7	26		
►	Home care workers available in East King County				75		HCATT baseline
√	Amy Wong Client Fund, under 60 clients	56	31 clients	30	32	$ 5,000	Combined Charities Catalog
√	Nurse consultation with high risk clients	462	439	375	377		Staffing changes in 2002
►	Hispanic clients	295	255	152	150		Staff reduction
	√ - Completed ►- Carried Forward **X -** Dropped						
	Housing						
	Secure housing with Section 8 vouchers for 30 younger clients with disabilities.						
√	Section 8 housing vouchers issued	42	67	23	30		King County Housing Authority
X	Cluster Care pilots						Administrative rules
√	Project-based Section 8 units		8	8	8		Overlake Village
►	**Increase affordable housing units in one rural area**						
	Number of new housing units.						
√	**Increase length of stay (months) for SHA case management clients**	28.2	38.7	35.2	36		
X	**Secure funding for homesharing matches in King County**						Reduction of King County funds

2000 – 2003 Area Plan Accomplishments

	Measures	2000	2001	2002	Projected 2003	2003 New Funds	Comments
	Family Caregivers						
	Increase caregivers receiving supportive information						
√	Family caregivers Website hits			82,493	90,000		
√	Family Caregiver phone calls		1838	9,995	4,500		
√	Funding	303	325	340	350		
√	Life Course Planning					$753,000	
	Home Care Quality						
√	**Increased funding for monitoring high risk clients who hire independent providers (IP)**						
X	**Younger disabled clients trained re: IP employment**						
	Increase monitoring of clients served by home care agencies						
►	Turnaround time from referral to placement						
√	Performance-base measures in home care contracts						
►	Home care aide time tracking system implemented						
	√ - completed ► - Carried Forward **X - Dropped**						

Appendix G
Statement of Assurances and Verification of Intent

For the period of January 1, 2004 through December 31, 2007, Aging and Disability Services accepts the responsibility to administer this Area Plan in accordance with all requirements of the Older Americans Act (OAA) (P.L. 106-510) and related state law and policy. Through the Area Plan, Aging and Disability Services shall promote the development of a comprehensive and coordinated system of services to meet the needs of older and disabled individuals and serve as the advocacy and focal point for these groups in the Planning and Service Area. The Aging and Disability Services assures that it will:

1. Comply with all applicable state and federal laws, regulations, policies and contract requirements relating to activities carried out under the Area Plan.

2. Conduct outreach, provide services in a comprehensive and coordinated system, and establish goals objectives with emphasis on: a) older individuals who have the greatest social and economic need, with particular attention to low income minority individuals and older individuals residing in rural areas; b) older individuals with severe disabilities; c) older Native Americans Indians who reside in rural areas; and d) older individuals with limited English-speaking ability.

   All agreements with providers of OAA services shall require the provider to specify how it intends to satisfy the service needs of low-income minority individuals and older individuals residing in rural areas and meet specific objectives established by Aging and Disability Services for providing services to low income minority individuals and older individuals residing in rural areas within the Planning and Service Area.

3. Provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, with agencies that develop or provide services for individuals with disabilities.

4. Provide information and assurances concerning services to older individuals who are Native Americans, including:

   A. Information concerning whether there is a significant population of older Native Americans in the planning and service area, and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under the Area Plan;

   B. An assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides with services provided under title VI of the Older Americans Act; and

   C. An assurance that the area agency on aging will make services under the Area Plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

5. Provide assurances that the area agency on aging, in funding the State Long Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of Title III funds expended by the agency in fiscal year 2000 on the State Long Term Care Ombudsman Program.

6. Obtain input from the public and approval from the AAA Advisory Council on the development, implementation and administration of the Area Plan through a public process, which should include, at a minimum, a public hearing prior to submission of the Area Plan to ADSA. Aging and Disability Services shall publicize the hearing(s) through legal notice, mailings, advertisements in newspapers, and other methods determined by the AAA to be most effective in informing the public, service providers, advocacy groups, etc.

9/17/03
Date

Director, Aging and Disability Services

9/17/03
Date

Chair, Advisory Council

9/17/03
Date

Legal Contractor Authority Director
Seattle Human Services Department

9/17/03
Date

Co-Sponsor
Director, King County Department of
Community & Human Services

9/17/03
Date

Co-Sponsor
Vice President of Community Services
United Way of King County

Appendix H: Guidelines from Sponsors to Planning & Allocation Committee RE: 2003-04 DISCRETIONARY ALLOCATIONS PROCESS

A. Give consideration to service areas currently funded by Aging and Disability Services (ADS) discretionary funds, by being alert to new and/or emerging needs.

B. Make distinctions between those services considered the primary responsibility of the ADS to fund, versus those that are primarily funded through other federal, State or County sources.

C. Coordinate with other funding sources in addressing community needs.

D. Take into account service area performance in meeting targeting standards, service delivery objectives, and geographic distribution.

E. Maintain the current funding policy, using any updated census data, for targeting to special populations (i.e. disabled, low-income, people of color, and rural isolation) as a priority. (*This item may be updated following the adoption of the revised Resource Allocation Tool.*)

F. Include a recommendation for a contingency fund.

G. Following the development of draft allocation recommendations, develop an unfunded priority list as part of the Committee's recommendations.

H. Follow the policy initiated in 1995 for phasing out discretionary funding to support the In-Home Health Maintenance service area, except for geographic areas where Medicaid funded Home Care services are not readily accessible.

In addition, the Sponsors have adopted the following preliminary criteria for considering funding reductions. Discretionary funding will be targeted for services which are:

- A core service that enables older people or adults with disabilities to remain in their home and in the community.
- Focused on serving older people or adults with disabilities who are frail, low income, ethnic minorities as a priority.
- Effective in meeting program outcomes
- Cost effective